Application for a Â§1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Washington** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of ?1915(c) of the Social Security Act.

B. Program Title:
Individual and Family Services

C. Waiver Number:WA.1186

D. Amendment Number:WA.1186.R02.01

E. Proposed Effective Date: (mm/dd/yy)

01/01/25

Approved Effective Date: 01/01/25
Approved Effective Date of Waiver being Amended: 09/01/24

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

• Add Foster Care group to waiver eligibility in Appendix B-4-b.
• Update assessment tool SIS-A to SIS-A 2nd Edition in Appendix B-6-d.
• Add Life Skills as a renamed service for Specialized Habilitation for WY 1-5 in Appendix C-1/C-3, Appendix I-2-a, Appendix J-2-c-i and J-2-d-ii.
• Add Stabilization Services - Life Skills as a renamed service for Stabilization Services - Specialized Habilitation for WY 1-5 in Appendix C-1/C-3, Appendix I-2-a, Appendix J-2-c-i and J-2-d-ii.
• Update qualifications for Case Resource Managers & Social Service Specialists to remove Bachelor’s degree requirement in accordance with SHB 2216 in Appendix B-6-c and D-1-a.
• Add University of Washington as contracted entity who will administer the NCI-IDD in person survey to a sample of HCBS waiver plan HCBS participants in Appendix A-3.
• Revise Transportation service definition and limitations to remove prohibitions against bus passes in Appendix C-1/C-3, C-2-e and add taxis and public transit as providers and rates in Appendix I-2-a.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted

concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Request, Purpose
☒ **Appendix A ? Waiver Administration and Operation**	A-3
☒ **Appendix B ? Participant Access and Eligibility**	B-4-b; B-6-d
☒ **Appendix C ? Participant Services**	C-1-1/C-3, C-2-e
☒ **Appendix D ? Participant Centered Service Planning and Delivery**	D-1-a
☐ **Appendix E ? Participant Direction of Services**	
☐ **Appendix F ? Participant Rights**	
☐ **Appendix G ? Participant Safeguards**	
☐ **Appendix H**	
☒ **Appendix I ? Financial Accountability**	I-2-a
☒ **Appendix J ? Cost-Neutrality Demonstration**	J-2-c-i, J-2-d-ii

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☒ **Modify Medicaid eligibility**

☒ **Add/delete services**

☒ **Revise service specifications**

☒ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☒ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Washington** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Individual and Family Services

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Waiver Number:WA.1186.R02.01
Draft ID: WA.029.02.01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 09/01/24
Approved Effective Date of Waiver being Amended: 09/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of

care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Waiver authorized under Section 1915(b)(4) for selective provider management for Respite service providers and waiver application has been approved by CMS.

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☒ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Individual and Family Services (IFS) Waiver it to provide support to individuals residing in the family home as an alternative to ICF/IID placement. The IFS waiver also supports children who are subject to a state court dependency proceeding pursuant to chapter 13.34 RCW or a similar proceeding in tribal court residing with paid or unpaid family.

The IFS Waiver is a partnership between the Developmental Disabilities Administration (DDA) and families to:

- Support DDA-eligible individuals living in the family home or who are in a State or Tribal dependency placement with their family;
- Provide waiver participants/families with a choice of services; and
- Allow individuals more control over the resources allocated to them.

The IFS Waiver will serve individuals who meet ICF/IID guidelines and have a natural support system. The Family's ability to continue caring for the client may be at risk but can be continued with the addition of services. Risk may be due to:

- The individual needs some support to participate successfully in the community; or
- The individual has physical assistance needs or medical problems requiring extra care; or
- The individual has behavioral episodes which challenge the family/caregiver's ability to support them; or
- The family/caregiver needs temporary or ongoing support to continue helping the individual remain in the family home.

The goal of the IFS Waiver is to support individuals (who require the level of care provided in an ICF/IID) who choose to remain in the family home or who hope to stay in family placement. This is accomplished by coordination of natural supports, community resources/services, Medicaid services and services available via the waiver. The DDA wants people who receive IFS Waiver services to experience these benefits:

- Health and Safety
- Personal Power and Choice
- Personal Value and Positive Recognition By Self and Others
- A Range of Experiences Which Help People Participate in the physical and social life of Their Communities
- Good Relationships with Friends and Relatives
- Competence to Manage Daily Activities and Pursue Personal Goals

The objective of the IFS Waiver is to support natural support systems and develop and implement supports and services to successfully maintain individuals in their family homes and communities.

With regard to the organizational structure, the State of Washington's HCBS IFS Waiver will be managed by the Developmental Disabilities Administration (DDA) within the Department of Social and Health Services (DSHS) which is the Operating Agency for this waiver. The DDA monitors against waiver requirements for all services delivered. The principles of Continuous Quality Improvement are used by the DDA to enhance the IFS Waiver services delivery system. The Medicaid Single State Agency (Health Care Authority-HCA) is responsible for approving rules, regulations and policies that govern how waivers are operated and retains the authority to discharge its responsibilities for the administration of the Medicaid program pursuant to 42 CFR §431.10(e).

All aspects of the Waiver will be directly managed by the state. The DDA operates this waiver within applicable federal regulations, manages the day-to-day administration and maintains operational responsibility for the waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization,

psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

IFS Waiver Renewal:
DDA designed the public stakeholder process to be very inclusive of stakeholder participation at every stage of waiver amendment development. DDA utilized electronic channels to inform stakeholders and solicit input on the draft waiver amendment. The State secured public input by working closely with the following:

- Other state agencies;
- County Coordinators for Human Services,
- The State of Washington Developmental Disabilities Council (DDC),
- The Washington State Department of Children, Youth, and Families,
- The Arc of Washington (advocacy organization), The Community Advocacy Coalition made up of advocates and providers,
- The HCBS (DDA) Quality Assurance Committee composed of self-advocates, advocates, and providers, and
- Stakeholders of the Washington State Department of Children, Youth and Families, including Tribes, children, youth, providers, parents, guardians, foster families, and suitable other persons.

The public process included the following:

• DDA posted public notice that the draft waiver amendments were available for public inspection online at DDA's website on August 7, 2024.

• DDA made the draft waiver amendments available to anyone who requested a copy of the amendments as a PDF document available on-line from DDA's public website on August 7th, 2023, through September 7th, 2024.

• DDA filed the public notice of the availability of the draft waiver amendments for public review in the Washington Register published on August 7th, 2024.

• DDA sent a letter on August 1st, 2024, to 26,000+ stakeholders, including participants, family members, advocacy organizations, providers and state staff, inviting their review and comments on the draft waiver amendments.

• Washington State Health Care Authority published a public notice to all Washington State Tribes on July 24nd, 2024, of DDA's intent to submit waiver amendments to the Centers for Medicare and Medicaid Services.

• Public comment period was extended to September 27, 2024, due to delayed release of letter to stakeholders.

Summary of Public Comments received and State's responses:
1. Two Commentors suggest that Community Engagement providers be trained and qualified as nurse delegators so that participants with medical needs could receive medical supports while the participants receive Community Engagement.
State Response: State will consider this suggestion in a future waiver amendment.
2. Commentor who is a provider of respite in the community and the father of a client requests higher rate for respite in the community providers as he states he is paid $.20 on the dollar for the services he chooses to offer clients.
State Response: State regularly reviews provider rates and is aware that the provider rate for respite in the community needs to be reviewed and updated if funded in future legislative session(s).
3. Commentor requests that Specialized Clothing be offered on the Basic Plus waiver as their son needs specialized clothing to meet his needs.
State Response: State agrees with this suggestion and this recommendation is included in a Legislative Report due December 1, 2024, that details a range of waiver restructure ideas.
4. Commentor requests that transportation be offered to a youth to and from college on the Basic Plus waiver.
State Response: State notes that this waiver amendment permits waiver transportation to be utilized to transport a waiver participant to where they need to go and is no longer limited to transportation to and from another waiver service.
5. Commentor requests that the assessment be updated to reflect when an adult client may never be left alone for even one hour.
State Response: State notes that the current DDA Assessment does capture the supervision needs of a waiver participant whether they might need 24/7 oversight.
6. Commentor requests more hours of service for 48-year-old daughter and challenges the expectation that parents in their 70s will be required to work part time for the rest of their lives to support their daughter.
State Response: State agrees that aging parents and caregivers may need more support for their adult children and the DDA Assessment is designed to capture this needed information. Additional supports will be explored for future program enhancements.
7. Commentor who has provided services for over 20 years requests more services as providers age.
State Response: State is aware that aging caregivers may require more support for their adult children and the DDA Assessment is designed to capture this needed information. Additional supports will be explored for future program enhancements.
8. Commentor who is parent of client receiving Core waiver services in SOLA expressed concern that client is not receiving all medically necessary supports.

State Response: State is committed to ensuring that all medically necessary supports for all clients in all waivers are provided as directed by medical professionals. DDA has an escalation process for referring cases of medical necessity to the client's managed care plan for state plan coverage when applicable.
9. Commentor suggests that Person-Centered Planning be available on all waivers.
State Response: State agrees with this suggestion and this recommendation is included in a Legislative Report due December 1, 2024, that details a range of waiver restructure ideas.
10. Commentor requests that the assessment specifically addresses apraxia and motor planning as clients with this diagnosis don't receive sufficient hours of waiver service or CFC personal care.
State Response: State will review this suggestion and consider any necessary changes to the assessment that includes this suggestion.

Continued at Main B. Optional

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Joseph

First Name: Tonik

Title: Assistant Secretary

Agency: Developmental Disabilities Administration, Department of Social and Health Services

Address: P.O. Box 45310

Address 2:

City: Olympia

State: **Washington**

Zip: 98504-5310

Phone: (360) 407-1564 **Ext:** ☐ **TTY**

Fax: (360) 407-0954

E-mail: Tonik.Joseph@dshs.wa.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Beckman

First Name: Bob

Title: Waiver Requirements Program Manager, Developmental Disabilities Administration

Agency: Developmental Disabilities Administration, Department of Social and Health Services

Address: P.O. Box 45310

Address 2:

City: Olympia

State: **Washington**

Zip: 98504-5310

Phone: (360) 407-1500 **Ext:** ☐ **TTY**

Fax: (360) 407-0955

E-mail: Beckmbc@dshs.wa.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Tonik Joseph

State Medicaid Director or Designee

Submission Date: Dec 27, 2024

Note: The Signature and Submission Date fields will be automatically completed when the State

Medicaid Director submits the application.

Last Name: Joseph

First Name: Tonik

Title: Assistant Secretary

Agency: Developmental Disabilities Administration/Department of Social and Health Services

Address: PO Box 45310

Address 2:

City: Olympia

State: **Washington**

Zip: 98504-5310

Phone: (360) 407-1564 **Ext:** ☐ **TTY**

Fax: (360) 407-0954

E-mail: Tonik.joseph@dshs.wa.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Continued from Appendix I-2-a.

The rate methodology for Remote Supports, Risk Assessment and Stabilization Services – Crisis Diversion Bed are negotiated rates researched and established by the Rates Unit of Management Services Division/ALTSA/DSHS and are based on the educational qualifications of providers (Ph.D, Masters & BA) and the provider status as an individual provider or agency staff. Rate ranges are reviewed every five years and rates for each provider are reviewed within their identified rate range at the time of provider recontracting. State utilized the cost build up approach. State looked up wages from the Bureau of Labor Statistics, Job Classes tab, based on the hourly mean wages of related positions in 2022. If it was determined that the service required multiple professionals to perform the service, then the average hourly means were added together to establish an hourly rate. To establish the rate range, the State took the average hourly wage and established the low end of the range by taking 90% of the hourly mean wage, multiplied that by 1.317 to add in taxes and benefits which can be found on the BLS benefits table tab, and added two years of inflation which was 4.4% per year. To establish the high end of the formula, the State took 110% of the hourly mean wage, multiplied by 1.317 to account for taxes and benefits, and added two years of inflation (4.4% per year) to the rate.

Continued from Appendix I-2-d.

The State implemented EVV for Personal Care, Skills Acquisition, Respite and Relief Care provided by individual providers and home care agencies effective January 1, 2021. EVV utilizes a 21st Century Cures Act compliant mobile application, Time4Care, to capture and report the six required data elements: 1) type of service performed including service delivery detail, activities and visit notes; 2) who received the service; 3) real time capture of date of the service; 4) who provided the service; 5) real time capture of location of service delivery via GPS; and 6) when the service begins and ends using real time clock in/clock out functionality.

• EVV is used to monitor the State’s financial integrity and accountability and reduce fraud, waste and abuse. The EVV application, Time4Care, has the following features:

- is 21st Century Cures Act compliant;
- allows for the control and flexibility of service delivery;
- the application is simple to use and records time offline without an internet connection;
- Time4Care is integrated with the WA IPOne web portal;
- Error trapping – Time4Care lets providers know in real time if there are problems with their data entries;
- Time4Care is designed to mitigate fraud, waste, and abuse.

This waiver provides Skilled Nursing, the only Home Health Care Service which is subject to the State's fully implemented EVV system.

The State's EVV system allows the location data, time-in and time-out data provided by the EVV system to be seen as a component of the State's MMIS, ProviderOne, which permits detailed monitoring of Skilled Nursing service delivery to waiver participants in their homes.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from Main 6. Requirements - Public Comments
11. Commentor who represents a specialized interpretation service including ASL, Spanish and other languages would like to be contracted to provide these services for clients.
State Response: State welcomes new providers and directs them to contact their closest resource developer to explore becoming a contracted.
12. Commentor requests that DDA acknowledge that a timely GovDelivery letter announcing the opportunity to comment on waiver amendments was not sent but acknowledges that the public comment period was extended from September 7 to September 27, 2024.
State Response: State acknowledges that a timely GovDelivery letter announcing the opportunity to comment on waiver amendments August 7 – September 7, 2024, was not sent and the comment period was extended from September 7 to September 27, 2024. State did post timely opportunity to comment on waiver amendments in the Washington Register published August 7, 2024, and State did post notices in all DDA offices concerning the opportunity to comment on waiver amendments.
13. Commentor requests that four elements of the assessment that are not part of the SIS be removed because they allege that the four elements perpetrate harmful labels for people, they lack validity, reliability and they cause harm to people receiving DDA services. The four items are: 1) managing attention seeking behavior; 2) managing uncooperative behavior; 3) managing agitated/over reactive behavior and 4) managing obsessive/repetitive behavior.
State Response: State appreciates all suggestions on improving the assessment instrument. Two legislatively mandated reports on the DDA Assessment, one by DDA and one produced for the Joint Legislative Audit and Review Committee, due in 2024, will provide suggestions for changes and improvements to the DDA Assessment that DDA will review and potentially request resources to implement in the future.
14. Commentor requests that State removes proposed Sexual Health Therapy service because they allege the service is harmful and stigmatizing due to the service providers being sex offender treatment providers. Commentor suggests that State offer actual sexual health therapy and references a Washington Department of Health article that defines sexual health as the ability to embrace and enjoy our sexuality throughout our lives by the American Sexual Health Association.
State Response: State notes that the proposed service, now renamed Sexual Safety Therapy, as suggested by the commentor, is designed to fill a gap in services that the state plan does not cover, that is the treatment of paraphilias. State will review revising the service in the future.
15. Commentor noted several clerical errors on amendment applications and missing financial information for Sexual Health Therapy.
State Response: State corrected clerical errors and added missing financial information for the service Sexual Safety Therapy for all five waivers.

Continued from C-1/C-3 Service Specifications - Remote Supports
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting. The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

Continued from C-4.a
The IFS support rating is added to the adjustment amount to yield the IFS services score, which in turns determines the IFS Waiver funding allocation amount, as contained in the first table above.

State will reevaluate benefit levels during the five year waiver cycle based on annual waiver Annual Per Capita expenditure data and propose changes based on utilization changes or service cost increases as necessary to the Washington Legislature and to

CMS.

State permits exceptions to rule (ETR) to exceed the maximum benefit level for exceptional expenditures when the IFS waiver will otherwise continue to meet the health and welfare needs of the waiver participant.

When IFS waiver participants demonstrate needs in excess of IFS waiver benefit levels and these needs will not be met with an exception to rule or require additional services not offered by the IFS waiver the participant may request and gain access to one of the State's other waivers that can meet the participant's needs.

The State mails two documents to the waiver participant to notify the participant of the benefit amount to which their waiver services are subject: the completed person-centered service plan (PCSP) and planned action notice (PAN).

(b) For complete details see WAC 388-828-9000-9140.

Continued from Appendix D Quality Improvement 1.a.ii

D.c.2: Person-Centered Service Plan Meeting Survey: A PCSP Meeting survey is mailed to waiver participants within one month of the PCSP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the PCSP process. The survey is mailed from DDA Central Office based on a random sample representative of all waivers with a 95% confidence level with a margin of error of +/-5%. Information collected is analyzed annually at the HCA Medicaid Agency Waiver Management Committee.
Questions in the Person-Centered Service Plan Meeting Survey include:

- Did you get to choose who came to your meeting?
- Did you get to choose the time and place of your meeting?
- Were you given the opportunity to lead your meeting?
- Were your personal goals discussed in developing your plan?
- Were you given a choice of services?
- Did you choose where and how the services will be provided?
- Did your case resource manager review last year's plan and ask what supports you want to continue and what should change?
- Were any concerns you may have had addressed in your new plan?
- Did you receive information about resources and services available to meet your goals?
- Were you given a choice of providers?
- Were plans made to meet any health and safety concerns you may have had?
- Did you receive information regarding planning for emergencies, such as an earthquake or other natural disaster?
- Do you know who to contact if your needs change before your next assessment?

D.d.5 Medicaid Services Verification Survey provides an additional data source for the state to discover/identify problems/issues with the waiver program.

QIPs for D.d.2, D.d.3 & D.e.1 are located at H-2-b

Continued from Appendix G-1-d.
DDA Policy 12.01 Incident Reporting and Management for DDA Employees and DDA Policy 12.03 SOCR (State-Operated Community Residential) Critical Incident Investigations detail procedures staff shall follow for evaluating and documenting follow-up actions to promote client health and welfare. Initial actions taken, including specific actions intended to promote client health and welfare, must be documented in the "Planned Health and Welfare Actions" section of the Incident Report. Planned health and welfare actions are steps taken by the provider, client, facility, family member, legal representative and DDA staff to promote the safety and well-being of each client involved in the incident. Health and welfare follow-up documentation describes services, staffing, referrals, or actions taken by the provider, client, facility, family member, legal representative and DDA staff to promote the health and welfare of the client pending the outcome of an investigation. Examples of follow-up actions include reconfiguring a household, requesting additional staffing, implementing a supervision plan, referring to payee services, and diversion placement.

RCW 26.44.100
Information about rights—Legislative purpose—Notification of investigation, report, and findings.
(1) The legislature finds parents and children often are not aware of their due process rights when agencies are investigating allegations of child abuse and neglect. The legislature reaffirms that all citizens, including parents, shall be afforded due process, that protection of children remains the priority of the legislature, and that this protection includes protecting the family unit from unnecessary disruption. To facilitate this goal, the legislature wishes to ensure that parents and children be advised in writing and orally, if feasible, of their basic rights and other specific information as set forth in this chapter, provided that nothing contained

in this chapter shall cause any delay in protective custody action.
(2) The department shall notify the parent, guardian, or legal custodian of a child of any allegations of child abuse or neglect made against such person at the initial point of contact with such person, in a manner consistent with the laws maintaining the confidentiality of the persons making the complaints or allegations. Investigations of child abuse and neglect should be conducted in a manner that will not jeopardize the safety or protection of the child or the integrity of the investigation process. Whenever the department completes an investigation of a child abuse or neglect report under this chapter, the department shall notify the subject of the report of the department's investigative findings. The notice shall also advise the subject of the report that:
(a) A written response to the report may be provided to the department and that such response will be filed in the record following receipt by the department;
(b) Information in the department's record may be considered in subsequent investigations or proceedings related to child protection or child custody;
(c) Founded reports of child abuse and neglect may be considered in determining whether the person is disqualified from being licensed to provide child care, employed by a licensed child care agency, or authorized by the department to care for children; and
(d) A subject named in a founded report of child abuse or neglect has the right to seek review of the finding as provided in this chapter.
(3) The founded finding notification required by this section shall be made by certified mail, return receipt requested, to the person's last known address.
(4) The unfounded finding notification required by this section must be made by regular mail to the person's last known address or by email.
(5) The duty of notification created by this section is subject to the ability of the department to ascertain the location of the person to be notified. The department shall exercise reasonable, good faith efforts to ascertain the location of persons entitled to notification under this section.
(6) The department shall provide training to all department personnel who conduct investigations under this section that shall include, but is not limited to, training regarding the legal duties of the department from the initial time of contact during investigation through treatment in order to protect children and families.

DDA Policy 12.01 Incident Reporting and Management for DDA Employees and DDA Policy 12.03 SOCR Critical Incident Investigations describe the steps DDA employees must take to document incidents, initiate actions to promote client health and welfare, plan and document follow-up steps pending the outcome of an investigation, and follow-up with the client and their legal representative to determine if health and welfare actions have been taken as planned or if plans are moving forward as expected. If planned health and welfare actions have not been implemented to the satisfaction of the client, their legal representative, or DDA, then DDA will ask the client or legal representative if they have any suggestions or changes they would like to make to the planned actions, document in the incident follow-up report the actions planned to address the remaining health and safety concerns, review follow-up actions no more than 90 days after the incident complete date, document completion of the review in the incident follow-up report, close the incident report no more than 90 days after the incident complete date, and document any activity beyond these timelines in a service episode record in CARE.

Child Protective Services rules are found at Chapter 110-30 WAC including how does CPS respond to reports of alleged child abuse or neglect (WAC 110-30-0070); what are the department’s responsibilities regarding notification of the parent or legal custodian in child protective services cases? (WAC 110-30-0130). CPS must notify the parent, guardian, or legal custodian of a child at the earliest possible point that will not jeopardize the investigation or the safety of the child. When must the department notify, guardian or legal custodian of allegations of child abuse or neglect made against them? (WAC 110-30-0140). CPS attempts to complete investigations within forty-five days (WAC 110-30-0070(7)).

Continued from Appendix G Quality Improvement 1.a.ii
QIP for Performance Measure G.a.2 - The percentage of incidents of alleged abuse, neglect, exploitation or abandonment in which the waiver participant and/or legal representative was contacted within 30 days to ensure safety plans were developed/appropriately implemented.

Sub-Assurance The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexpected death.

Performance Measure G.a.2: The percentage of incidents of alleged abuse, neglect, exploitation or abandonment in which the waiver participant and/or legal representative was contacted within 30 days to ensure safety plans were developed/appropriately implemented. N = # of reviewed incidents in which the waiver participant and/or legal representative was contacted within 30 days to ensure safety plans were developed/appropriately implemented. D = Number of reviewed incidents of alleged abuse, neglect, exploitation or abandonment.

Current compliance is 50% and trending down
Root cause: Field Staff compliance
Remediation Plan:
- Report created and distributed to field in third quarter of 2021
- Require staff follow up
- CARE change request for additional ticklers to supervisor and Incident Report Program Manager
- In October 2021 new statewide standardized training on IR follow up was rolled out

Remediation Goal: 100% follow up after a critical incident to ensure client health and welfare
Implementation Plan:

HQ Responsibilities	Field Implementation Expectations
Report created for field staff (already available)	
• Create MB or policy to make 30 day follow up a quality assurance task for supervisors to ensure their staff have completed the 30 day follow up contact • 15 day canned report on follow up	• Supervisors to receive report and expectation of follow up as a mandatory supervisory expectation • FSAs attend Regional Quality Assurance meeting to review Quality compliance
CARE Change Request	
• Add tickler to CARE for assigned supervisor at 20 days • Develop MB guidance on remediation expectations for supervisor follow up	• Supervisor will receive notification tickler and follow up with staff and ensure 30 day IR follow up is completed
Develop MB and Policy on Remediation Expectations	
• HQ will outline clear expectations related to IR 30 day critical incident follow up, and all of the above mentioned strategies. • Require supervisor to ensure 30 day follow up in MB	• Field staff will begin, at effective date of the MB, to implement the remediation strategies
In October 2021 new statewide standardized training including IR follow up	
• HQ will review and monitor training schedule and staff attendance	• Field Staff will attend scheduled trainings

Update for G.a.2:
- CMS's comment: "For PM G.a.2, the state met compliance with this performance measure in the consolidated quality review that included data for this waiver in July 2021. Therefore, the state was not required to submit quality data for this performance measure for this quality review."

Appendix I-2 Rate Determination Methods - Information placed here due to lack of capacity at Appendix I-2.

Environmental Adaptations, Therapeutic Adaptations, & Vehicle Modifications: Rates are based upon bids received by potential contractors. Variations in rates are due to differences among providers related to overhead, staff wages, and the local demand for services. Rates are adjusted as the bids change over time, which in turn are based on the local cost of goods & labor & the demand for the service. Providers initiate the change in payment by the bids they submit. DDA will review the rates being paid annually using rate comparisons. Rates will be increased if current rates are significantly (e.g., 20%) less than prevailing market rates.

Nurse Delegation, Skilled Nursing: Nurse Delegation: market value, including Medicaid reimbursement rates, are reviewed and final rate is set by legislature
Skilled Nursing: market value, including Medicaid reimbursement rates, are reviewed and final rate is set by legislature.
Rates are based on Medicaid unit rates with no vacation or overtime. Changes to flat rates such as these are initiated, mandated and funded by the Legislature during legislative sessions, which are held annually. Adjustments to the rates will be made by the HCA. HCA rates are updated every January with any possible new codes, & rates are changed every July to align with new RVUs, State GPCI, & State specific conversion factor. For codes that do not have RVUs, analysis is completed and rates are usually set at a flat rate. If analysis shows they need to be updated, that will occur every July with the other codes.

The State Medicaid Agency is required to follow the Administrative Procedure Act, Chapter 34.05 RCW when soliciting public comments on rate determination methods. Changes to rates that are made by the legislature in the biennial and supplemental budget process are part of public hearings on budget and policy legislation. Rates are posted on public web sites.

Wellness Education rate is a flat fee based on actual cost for production of the service. The current Wellness Education provider's contract is renewed annually.

The State publishes its fee schedules at: https://www.dshs.wa.gov/altsa/management-services-division/office-rates-management.

Supported Parenting Services – Fee Schedule Rate based on market analysis: Rates are researched and established by the Rates Unit of Management Services Division/ALTSA/DSHS and are based on the provider status as an individual provider or agency staff. Rate ranges are reviewed every three years and rates for each provider are reviewed within their identified rate range at the time of provider re-contracting.

Specialized Habilitation and Stabilization Services – Specialized Habilitation, Life Skills, Stabilization Services - Life Skills, Stabilization Services – Staff/Family Consultation Services, Staff/Family Consultation Services, : Negotiated Rates are researched and established by the Rates Unit of Management Services Division/ALTSA/DSHS and are based on the educational qualifications of providers (Ph.D, Masters & BA) and the provider status as an individual provider or agency staff. Rate ranges are reviewed every five years and rates for each provider are reviewed within their identified rate range at the time of provider re-contracting. For Specialized Habilitation and Stabilization Services – Specialized Habilitation, Stabilization Services – Staff/Family Consultation Services State utilized the cost build up approach. State looked up wages from the Bureau of Labor Statistics, Job Classes tab, based on the hourly mean wages of related positions in 2017. If it was determined that the service required multiple professionals to perform the service, then the average hourly means were added together to establish an hourly rate. To establish the rate range, the State took the average hourly wage and established the low end of the range by taking 90% of the hourly mean wage, multiplied that by 1.317 to add in taxes and benefits which can be found on the BLS benefits table tab, and added two years of inflation which was 4.4% per year. To establish the high end of the formula, the State took 110% of the hourly mean wage, multiplied by 1.317 to account for taxes and benefits, and added two years of inflation (4.4% per year) to the rate.

Shoppers for Assistive Technology, Therapeutic Adaptations and Specialized Equipment and Supplies - Fixed rate: The Contractor shall be reimbursed $8.00 per 15 minute units for the time spent completing tasks under this contract (including, but not limited to shopping, arranging for set-up, and transportation).

Transportation-Fee Schedule:
Individual provider & agency hourly rates & the mileage rate for transportation are based upon the rates provided to personal care providers. Those provider rates are standardized based on negotiations with the Service Employees International Union (SEIU) & funding provided by the Legislature. Changes in rates may be proposed by either party during the negotiations for contract terms, held every two years. DDA will adjust the rates whenever the negotiated rates change, which is expected to be every two years. The rate for transportation is changed based on significant (e.g., 20%) increases in the cost of vehicle maintenance & repair costs & the cost of fuel. HCA Contracted Non-Emergency Medical Transportation Brokers – market rate; Non-Emergency Medical Transportation Companies – market rate. Taxis, public transit - market rate.

Continued at Main.A.Attachment #2

Appendix G-1.d Responsibility for Review of and Response to Critical Events or Incidents
RCS's Operations Manual specifies that the RCS staff or contracted evaluators will hold an exit conference with the provider and invite participants, families, their representatives or advocates and DDA Case/Resource Managers following the investigation and prior to the formal issuing of a statement of deficiencies. The exit conference is conducted to identify and summarize for the provider the deficient practices and regulations that will be cited in the statement of deficiencies report and to identify issues that are still being considered for possible citation. RCS will remind the provider of the responsibility to immediately initiate corrective action of identified deficient practices. The formal statement of deficiencies must be mailed to the provider within 10 working days after the last day of data collection.

RCW 26.44.100
Information about rights—Legislative purpose—Notification of investigation, report, and findings.
(1) The legislature finds parents and children often are not aware of their due process rights when agencies are investigating allegations of child abuse and neglect. The legislature reaffirms that all citizens, including parents, shall be afforded due process, that protection of children remains the priority of the legislature, and that this protection includes protecting the family unit from unnecessary disruption. To facilitate this goal, the legislature wishes to ensure that parents and children be advised in writing and orally, if feasible, of their basic rights and other specific information as set forth in this chapter, provided that nothing contained in this chapter shall cause any delay in protective custody action.
(2) The department shall notify the parent, guardian, or legal custodian of a child of any allegations of child abuse or neglect

made against such person at the initial point of contact with such person, in a manner consistent with the laws maintaining the confidentiality of the persons making the complaints or allegations. Investigations of child abuse and neglect should be conducted in a manner that will not jeopardize the safety or protection of the child or the integrity of the investigation process. Whenever the department completes an investigation of a child abuse or neglect report under this chapter, the department shall notify the subject of the report of the department's investigative findings. The notice shall also advise the subject of the report that:
(a) A written response to the report may be provided to the department and that such response will be filed in the record following receipt by the department;
(b) Information in the department's record may be considered in subsequent investigations or proceedings related to child protection or child custody;
(c) Founded reports of child abuse and neglect may be considered in determining whether the person is disqualified from being licensed to provide child care, employed by a licensed child care agency, or authorized by the department to care for children; and
(d) A subject named in a founded report of child abuse or neglect has the right to seek review of the finding as provided in this chapter.
(3) The founded finding notification required by this section shall be made by certified mail, return receipt requested, to the person's last known address.
(4) The unfounded finding notification required by this section must be made by regular mail to the person's last known address or by email.
(5) The duty of notification created by this section is subject to the ability of the department to ascertain the location of the person to be notified. The department shall exercise reasonable, good faith efforts to ascertain the location of persons entitled to notification under this section.
(6) The department shall provide training to all department personnel who conduct investigations under this section that shall include, but is not limited to, training regarding the legal duties of the department from the initial time of contact during investigation through treatment in order to protect children and families.
RCW 26.44.100
Information about rights—Legislative purpose—Notification of investigation, report, and findings.
(1) The legislature finds parents and children often are not aware of their due process rights when agencies are investigating allegations of child abuse and neglect. The legislature reaffirms that all citizens, including parents, shall be afforded due process, that protection of children remains the priority of the legislature, and that this protection includes protecting the family unit from unnecessary disruption. To facilitate this goal, the legislature wishes to ensure that parents and children be advised in writing and orally, if feasible, of their basic rights and other specific information as set forth in this chapter, provided that nothing contained in this chapter shall cause any delay in protective custody action.
(2) The department shall notify the parent, guardian, or legal custodian of a child of any allegations of child abuse or neglect made against such person at the initial point of contact with such person, in a manner consistent with the laws maintaining the confidentiality of the persons making the complaints or allegations. Investigations of child abuse and neglect should be conducted in a manner that will not jeopardize the safety or protection of the child or the integrity of the investigation process. Whenever the department completes an investigation of a child abuse or neglect report under this chapter, the department shall notify the subject of the report of the department's investigative findings. The notice shall also advise the subject of the report that:
(a) A written response to the report may be provided to the department and that such response will be filed in the record following receipt by the department;
(b) Information in the department's record may be considered in subsequent investigations or proceedings related to child protection or child custody;
(c) Founded reports of child abuse and neglect may be considered in determining whether the person is disqualified from being licensed to provide child care, employed by a licensed child care agency, or authorized by the department to care for children; and
(d) A subject named in a founded report of child abuse or neglect has the right to seek review of the finding as provided in this chapter.
(3) The founded finding notification required by this section shall be made by certified mail, return receipt requested, to the person's last known address.
(4) The unfounded finding notification required by this section must be made by regular mail to the person's last known address or by email.
(5) The duty of notification created by this section is subject to the ability of the department to ascertain the location of the person to be notified. The department shall exercise reasonable, good faith efforts to ascertain the location of persons entitled to notification under this section.
(6) The department shall provide training to all department personnel who conduct investigations under this section that shall include, but is not limited to, training regarding the legal duties of the department from the initial time of contact during investigation through treatment in order to protect children and families.

Appendix G-2.a.i Safeguards Concerning the Use of Restrains
CRMs and SSSs document all recommended interventions and supports in accordance with State policy and rule in participants' PCSPs and Positive Behavior Support Plans (PBSPs). By policy and rule, any recommended intervention in a PCSP and PBSP must cause no harm to the participant.

Appendix G-3.b.i Medication Management and Follow-Up Responsibility
Residential Care Services (RCS) provides the primary second-line monitoring of medication management for those receiving services from a DDA residential habilitation service as a component of their every two-year certification process. The re-certification process includes on-site observations of staff/participant interactions, medication record reviews and participant and provider staff interviews. When deficiencies are detected, statements of deficiencies (SOD) are issued and immediate remediation is required by providers. Follow-up on-site visits are made by RCS certifiers to confirm that required remediation has occurred.

DDA also provides several levels of second-line monitoring of medication management. DDA Residential Quality Assurance (QA) staff review all residential Statements of Deficiency (SODs) in real time and review aggregated SOD data on a monthly basis to discover trends or patterns. When DDA Residential QA staff discovers trends or patterns with SODs, DDA works with RCS to ensure corrective action happens. DDA's Incident Report (IR) committee samples incident reports on a monthly basis to discover trends or patterns which may include issues with medication management. DDA Mortality Review Committee reviews all deaths in residential programs and all unexpected deaths on a monthly basis to determine if deaths were preventable. The DDA Assessment/re-assessment requires the Case/Resource Manager or Social Services Specialist (SSS) to annually or more frequently if participant needs change document all participant medications, their dosage, frequency, route and why taken on the CARE Medications screen. On the Medication Management CARE screen, the CRM or SSS documents self-administration, status (met, partial met, unmet), frequency, assistance available, participant strengths, participant limitations, participant preferences, caregiver instructions, equipment/supplies and comments. CRMs or SSSs monitor medication management to the frequency necessary to maintain client health and safety. The DDA assessment will trigger a referral requirement if medication risk factors are identified. Once this requirement is triggered the CRM or SSS must address the risk identified in the PCSP. How the risks are addressed depends on the concern identified. It could result in a medication evaluation referral, additional provider training, nurse oversight visits, consultation with the healthcare provider or other measures. Results of all monitoring are documented by the CRM or SSS in the CARE tool on the monitoring screen or as service episode records (case notes). Periodic monitoring by the CRM or SSS on a semi-annual, quarterly or monthly basis determined by the complexity of the participant's needs combined with quality assurance oversight by the annual QCC team file review assures that potentially harmful practices are detected and remediated.

Continued from Appendix H-1.b.ii Quality Improvement Strategy - System Design Changes

3.c. Process for identifying and analyzing patterns/trends.

The processes for identifying and analyzing patterns/trends are identical across all DDA HCBS waivers.

Data that is analyzed to identify patterns and trends comes from:
- QCC reviews
- CARE
- National Core Indicators
- PCSP satisfactions surveys
- Fiscal reports
- CRM face to face meeting data
- Incident Reports
- Complaint Data Base
- Mortality Review Team Reviews

Many entities help the DDA identify and analyze patterns and trends by reviewing reports and QIS data, including:
- DDA Executive Management, including the DDA Assistant Secretary, DDA Deputy Assistant Secretary, DDA Division Directors, DDA Office Chiefs, DDA Unit Managers, and DDA regional waiver and quality assurance specialists.
- DDA Incident Review Team, which meets monthly to review aggregate data from the Electronic Incident Reporting System and makes recommendations to prevent incidents.
- DDA Mortality Review Team, which meets monthly to review deaths of waiver participants and identify, monitor and make recommendations concerning mortality trends and patterns.

• Stakeholders, who can access a dedicated internet site which offers them an opportunity to review annual waiver reports, review quality assurance activities, provide input on needed changes, provide suggestions for ways to better served waiver participants, and participate in an on-going dialogue about the quality of services for individuals on the DDA HCBS waivers.

• DDA HCBS Waiver Quality Assurance Committee, which is sponsored by the DDC and is comprised of self-advocates, family members, providers and Administration representatives and meets four times a year (with provision for sub-committees as needed) to provide oversight of and guidance for the DDA HCBS Waiver program.

• Developmental Disabilities Council (DDC) which provides recommendations for improvement using the National Core Indicators Survey as the tool to identify trends and patterns.

• HCA Medicaid Agency Waiver Management Committee, which includes representatives from the Health Care Authority (the single State Medicaid Agency) and Administrations/Divisions within the operating agency and meets quarterly to review all functions delegated to the operating agency, current quality assurance activities and reports, pending waiver activity and potential waiver policy and rule changes and quality improvement activities.

3.d. Majority of the performance indicators are the same.
Currently ninety-six percent (96%) of the performance measures that apply to the DDA HCBS waiver program are common across all five waivers. The remainder are unique to individual waivers based on the populations served and the types of services covered.
4. The provider network is the same or very similar.
Provider networks across all waivers are very similar due to the services that the waivers have in common.
5. Provider oversight is the same or very similar.
Provider oversight is the same across all waivers due to the use of common mechanisms (e.g. Agency Contracts Database), standardized contracts, and standardized protocols for provider oversight that are implemented by state staff employed at the regional level.
A consolidated evidence report is published annually in the fall for all waivers. Evidence for any assurances not met, evidence for performance measures that are unique to any waivers and individual activities for remediation in instances of abuse, neglect and/or exploitation are included in the consolidated evidence report.

Appendix G-1.b. Continued
ONE-DAY PROTOCOL
A. One-day protocol requires a DDA employee to submit an incident report no more than one working day after becoming aware of an incident.
B. A DDA employee must follow one-day protocol if any of the following occur:
1. Alleged or suspected abuse, improper use of restraint, neglect, self-neglect, personal or financial exploitation, or abandonment of a client by a DSHS employee, volunteer, licensee, or contractor.
2. A client is injured following the use of a restrictive procedure or physical intervention.
3. A client's injury, regardless of origin, requires professional medical attention.
4. A client's injury of unknown origin raises suspicion of abuse or neglect due to:
a. The extent of the injury;
b. The location of the injury, such as an area not typically vulnerable to trauma;
c. The number of injuries observed at a specific point in time;
d. Repeated injuries of unknown origin; or
e. The client's condition.
5. Known criminal activity perpetrated by a DSHS employee, volunteer, licensee, or contractor that may impact the person's ability to perform the duties required of their position.
6. Criminal activity by a client that results in a case number being assigned by law enforcement.
7. Alleged sexual abuse of a client (if not reported under one-hour protocol above).
8. Client-to-client abuse under RCW 74.34.035, which applies to clients 18 and older and includes:
a. Injuries (e.g. bruising, scratches, etc.) that appear on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal areas;
b. Fractures;
c. Choking attempts; or
d. Patterns of physical assault between the same vulnerable adults or involving the same vulnerable adults.
9. A client is missing. A client is considered missing if:
a. The client's assessed support level in their person-centered service plan (PCSP) is 4, 5, or 6, their whereabouts are unknown, and the client cannot be contacted for two hours, unless the client's DDA CARE assessment or PCSP indicates a different time period;

b. The client's assessed support level in their PCSP is 1, 2, 3a, or 3b and the client is out of contact with staff for more time than is expected based on their typical routine, DDA CARE assessment, or PCSP; or

c. The client is located by a first responder, police officer, or community member and the provider was unaware that the client was gone.

Note: A client without good survival skills may be considered in "immediate jeopardy" when missing for any period of time based upon the client's personal history regardless of the hours of service received. This includes clients with identified community protection issues.

10. Death of a client that doesn't require one-hour protocol.
11. Death of a live-in care provider
12. Impatient admission to a state or local psychiatric hospital or evaluation and treatment center.
13. Alleged or suspected abuse, abandonment, neglect, personal or financial exploitation by another person (who is not a client or staff), that is screened in by APS, CPS or RCS for investigation.
14. Criminal activity against a client resulting in a case number being assigned by law enforcement.
15. Use of a restrictive procedure, on an emergency basis, that is not part of the client's approved Positive Behavior Support Plan (PBSP).
16. A medication or nurse delegation error that caused or is likely to cause injury or harm to a client according to a pharmacist, nurse, or other medical professional.
17. A pattern of medication errors involving the same client or the same staff.
18. Emergency medical hospital admissions.
19. A client or the client's legal representative are contemplating a permanent sterilization procedure.
20. A community protection client signs out or leaves the program without intent to return.
21. A client's provider or family declines to support the client after discharge from a medical or psychiatric facility.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Department of Social and Health Services/Developmental Disabilities Administration

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Specify the functions that are expressly delegated through a memorandum of understanding between the Health Care Authority (HCA, the Single State Medicaid Agency) and the Department of Social and Health Services/Developmental Disabilities Administration (DSHS/DDA/the Operating Agency):

Schedule A5 of the Cooperative Agreement between the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) delegates the following functions to the operating agency:
-Submission of all necessary application, renewal and amendment materials to CMS in order to secure and maintain approval of all proposed and existing waivers;
-Responsibility for the operation, management, and reporting of allowable Medicaid administrative activities for approved federal waivers; and
-Developing regulations, MMIS policy changes, and provider manuals.

The Cooperative Agreement is reviewed and updated when needed as issues are identified.

The Medicaid agency (HCA) is responsible for approving rules, regulations and policies that govern how waivers are operated and retains the authority to discharge its responsibilities for the administration of the Medicaid program pursuant to 42 § CFR §431.10(e). The assigned operational and administrative functions are monitored as part of the Aging and Long-Term Support Services Administration's (ALTSA's)/Developmental Disabilities Administration's (DDA's) annual Quality Assurance (QA) review cycle. Final QA outcome reports are provided to the Medicaid agency for review and follow-up.

At the end of each QA review cycle, a final report is generated which includes detailed data on a statewide level. These results are analyzed and incorporated into a statewide proficiency improvement plan. The State Medicaid Agency receives annual QA review reports and meets with the operating agency at the conclusion of the QA cycle to review results and provide input into the proficiency improvement plan. The proficiency improvement plan is reviewed and approved for implementation by DDA executive management.

The Medicaid Agency Waiver Management Committee was created and includes representatives from divisions within the operating agency, Home and Community Services (HCS) and Residential Care Services (RCS), and from two other DSHS administrations: Developmental Disabilities Administration (DDA) and Behavioral Health Administration (BHA) and the Department of Children, Youth and Families (DCYF). The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g. amendments, renewals, etc.), potential waiver policy and rule changes and quality improvement activities.

The State’s Medicaid agency, the Health Care Authority, employs oversight methods that cover the full range of responsibilities specified in item A-7, including participant waiver enrollment, waiver enrollment managed against approved limits, waiver expenditures managed against approved levels, level of care evaluation, review of participant service plans, prior authorization of waiver services, utilization management, qualified provider enrollment, execution of Medicaid provider agreements, establishment of a statewide rate methodology, rules, policies, procedures and information development governing the waiver program and quality assurance and quality improvement activities. The oversight methods include: a Cooperative Agreement between the Medicaid agency, the Health Care Authority (HCA), and the operating agency, the Department of Social and Health Services (DSHS), that expressly details the delegated functions performed by the operating agency; the Medicaid Agency Waiver Management Committee that reviews all functions delegated to the operating agency and includes representatives from within administrations of the operating agency, including Aging and Long Term Supports Administration’s (ALTSA) Home and Community Services (HCS), Residential Care Services (RCS), Adult Protective Services (APS), Developmental Disabilities Administration (DDA) and the Department of Children, Youth and Families’(DCYF) Child Protective Services (CPS) and the HCA.
Oversight methods also include the State Auditor which performs audits of all activities of the operating agency; the operating agency’s Quality Assurance programs which systematically oversee all quality control systems, measures and processes; cost report auditing by the Management Services Division (MSD) of ALTSA for residential provider expenditures; rates development, management and oversight for contracted providers by the DDA Rates Unit of MSD; and legislative oversight of all aspects of waiver programs by the Joint Legislative Audit & Review Committee (JLARC).

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Sate will contract with the University of Washington to conduct the NCI-IDD in person survey to a statistically valid random sample of HCBS waiver and state plan HCBS participants as a component of the CMS-required Quality Measure Set specified in the final Medicaid Access Rule.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

. Department of Social and Health Services
Developmental Disabilities Administration

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Each biennium, DDA reviews and evaluates the state's Employment & Day program subcontractors. The evaluation incorporate all contractual requirements including but not limited to waiver participant direct services, program quality assurance, indirect systems, policies and procedure, and fiscal soundness. All counties are asked to complete and return the Employment & Day Contract Compliance review checklist, which is a self-assessment tool.

In addition to the tool, DDA asks counties to submit various other information examples of requested information include:
- Their most recent Request for Qualifications for Employment & Day Program Services.
- Their site review schedule including dates and the names of providers to be reviewed.
- An overview of their "Quality Assurance & Evaluation" process including:
  - A sample site review engagement letter.
  - The evaluation tool used for the site review.
  - A sample follow-up site review letter (preferably a corrective action sample).
  - An explanation of how client review sampling is determined.

Once information is obtained, DDA compiles the information and determines which counties should be first reviewed on-site. Counties who delay submission of requested information, have new staff, or have reported issues from the field are first reviewed on-site. Thus DDA conducts an one hundred percent (100%) onsite review of all counties. Based on the information provided, DDA determines which Counties first require on-site reviews and technical assistance.

When on-site reviews are conducted:

Waiver participant files will be reviewed for specific elements including:
- Relationship of clients file notes describing services - to reporting documents - to DDA's Person-Centered Service Plan;
- Quality of reporting documents, activity progress and outcome status;
- Accuracy of service hours reported, including separation of Department of Vocational Rehabilitation (DVR) hours;
- Required documentation such as grievance procedures, medical information, release of information, etc.

Direct service staff files will be reviewed for specific elements including:
- Background checks;
- Qualifications;
- Training information; and
- Documentation of Policy Review.

As a result of the site visits, counties receive written feedback which includes recommendations for necessary corrective action.

The Medicaid Agency is responsible for approving rules, regulations and policies that govern how waivers are operated. The assigned operational and administrative functions are monitored as part of DDA's annual QA Review Cycle. At the end of each annual QA Review Cycle a report is generated which includes detailed data on a state-wide level. Final QA outcome reports are provided to the Medicaid Agency for review and input. Monitoring results are also reviewed with the Medicaid Agency Waiver Oversight Committee at the quarterly meeting of the Committee immediately following compilation of the monitoring results.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed

directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care waiver eligibility evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☐
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☒
Execution of Medicaid provider agreements	☒	☒	☒
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
A.2. Number & percent of scheduled meetings of the HCA Medicaid Agency Waiver Management Committee that are held. N = Number of scheduled meetings of the HCA Medicaid Agency Waiver Management Committee that are held. D = Total number of scheduled meetings of the HCA Medicaid Agency Waiver Management Committee.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.3. Number & percent of waiver deliverables that comply with the Interagency Cooperative Agreement as documented by acceptance letters from HCA. N = Number of waiver deliverables that comply with the Interagency Cooperative Agreement as documented by acceptance letters from HCA. D = Total number of waiver deliverables. D = Total number of waiver deliverables.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.1. Number & percent of waiver, waiver amendment & waiver renewal requests submitted to CMS for which approval was obtained from Single State Medicaid Agency. N = # of wvr, wvr amdmt and wvr renewal requests submitted to CMS for which approval was obtained from SSMA. D = Total # of wvr, wvr amdmt & wvr renewal requests submitted to CMS.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

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

A.1: The State Operating Agency obtains written approval from the Single State Medicaid Agency (Health Care Authority-HCA) to submit initial waiver requests, waiver amendment requests and waiver renewal requests to CMS. The Waiver Services Unit Manager verifies annually that approval from the HCA was obtained for all waiver amendment requests and waiver renewal requests submitted to CMS.

A.2: The HCA Medicaid Agency Waiver Management Committee includes representatives from the HCA and Administrations and Divisions within the operating agency: DDA, HCS, RCS, and BHA. The committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g., amendments, renewals), potential waiver policy and rule changes and quality improvement activities. The Waiver Services Unit Manager verifies annually that these meetings were held.

A.3 The Operating Agency obtains written permission from the Health Care Authority prior to submitting waiver amendments, renewals or new waiver applications to CMS as confirmation that waiver deliverables are in compliance with the Interagency Cooperative Agreement.

b. Methods for Remediation/Fixing Individual Problems

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

A.1 & A.3: If it is determined that HCA approval was not obtained for all initial waiver requests, waiver amendment or waiver renewal requests submitted to CMS, the Waiver Services Unit Manager will ensure that approval from the HCA will be obtained and processes will be reviewed and evaluated to determine if changes need to be made to ensure prospective approval is obtained in the future.

A.2: If the HCA Medicaid Agency Waiver Management Committee did not meet quarterly, the Waiver Services Unit Manager will ensure the process is modified as necessary so that in the future quarterly meetings are held.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
Intellectual Disability or Developmental Disability, or Both					
	☒	**Autism**	0		☒
	☒	**Developmental Disability**	0		☒
	☒	**Intellectual Disability**	0		☒
Mental Illness					

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Individuals must meet the Developmental Disabilities Administration (DDA) definition of developmental disability as contained in state law (Revised Code of Washington-RCW) and stipulated in Washington State administrative code (WAC) and meet additional criteria as specified in state administrative code.

Washington State regulations and administrative codes stipulate that in order to qualify for DDA the individual must have a diagnosed condition of:

(1) Intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition found by DDA to be closely related to intellectual disability or requiring treatment similar to that required for individuals with intellectual disability which;

(a) Originates prior to age eighteen;

(b) Is expected to continue indefinitely;

(c) Results in substantial limitations; and

(2) Must not be residing in hospital, jail, prison, nursing facility, ICF/IID, or other institution; or

(3) You meet all criteria in (1) and (2) and you are subject to a state court dependency proceeding pursuant to chapter 13.34 RCW or a similar proceeding in tribal court, are receiving extended foster care services, or exited a dependency or discontinued extended foster care services from the Department of Children, Youth and Families or from a Tribe in Washington State.

(4) In addition to the requirements listed in (1) above, the individual must meet the other requirements contained in Chapter 388-823 WAC (concerning Developmental Disabilities Administration intake and eligibility determination).

To be on the IFS Waiver, individuals who meet ICF/IID level of care guidelines must meet the following additional criteria:

- Live in the family home with your family, family foster parents, or non-paid relatives;
- Have been assessed as having a need for IFS waiver services;
- Are not enrolled on another DDA or Home and Community Services (HCS) Home and Community Based Services (HCBS) waiver; and
- Are not receiving a DDA adult or child residential service or receiving licensed foster care.

A parent who is a client of DDA is eligible to receive IFS Waiver services in order to promote the integrity of the family unit, provided:

a) All of the criteria identified above are met; and

b) The minor child who lives in the parent's home is at risk of being placed out of home (e.g., up for adoption, into foster care or into an ICF/IID).

HCA, DSHS/DDA, and the Department of Children, Youth and Families (DCYF) will have a service level agreement by September 1st, 2024 that specifies the functions that DCYF fulfills for children and youth age 20 and younger who are subject to a state court dependency proceeding pursuant to chapter 13.34 RCW or a similar proceeding in tribal court, who choose to enroll and participate in DSHS/DDA’s Medicaid waiver programs. DCYF children and youth age 20 and younger who are subject to a state court dependency proceeding pursuant to chapter 13.34 RCW or a similar proceeding in tribal court, must meet DSHS/DDA’s Medicaid waiver eligibility criteria to enroll in DSHS/DDA’s Medicaid waiver programs.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

◉ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

Eligibility limit is $4,680 per year. Data from past years demonstrates that the individual cost limit is sufficient to meet the needs of the target population for this waiver.
Individuals are not expected to lose services due to cost limits.
The individual cost limit is applied uniformly and fairly to all potentially eligible individuals.
The state does not expect that individuals will no longer be eligible upon re-evaluation.
The expenditure limits do not include expenditures for personal care. These services are available to waiver participants outside of the waiver as a Section 1915(k) Medicaid State Plan service.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

◉ **Other:**

Specify:

$4,680 per year.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Individuals are assigned to the IFS waiver based on assessed need. If a client's needs exceed the cost limits the individual would not be placed on the IFS waiver. Analysis of IFS experience has demonstrated that the cost limit is functional for the majority of IFS participants.
All waiver participants receive the same comprehensive assessment by trained Case Resource Managers. DDA's QIS system insures that all Case Resource Managers are uniformly and consistently assessing all eligible individuals. The individual cost limit is applied uniformly and fairly to all potentially eligible individuals.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☒ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Additional services in excess of the individual cost limits may be authorized short term (up to 90 days) when a waiver participant requires additional support for a brief period of time in order to ensure the health and welfare of the individual. These additional supports are limited to the services provided in the IFS waiver.
As stated in WAC 388-845-3085:
(1) If you are on the IFS, CIIBS, Core, Basic Plus or Community Protection waiver and your assessed need for services exceeds the scope of services provided under your waiver, DDA will make one or more of the following efforts to meet your health and welfare needs:
(a) Identify more available natural supports;
(b) Initiate an exception to rule to access available nonwaiver services not included in the IFS, CIIBS, Core, Basic Plus or Community Protection waiver other than natural supports;
(c) Offer you the opportunity to apply for an alternative waiver that has the services you need, subject to WAC 388-845-0045; or
(d) Offer you placement in an IFC/IID.
(2) If none of the above options is successful in meeting your health and welfare needs, DDA may terminate your waiver eligibility.
(3) If you are terminated from a waiver, you will remain eligible for nonwaiver DDA services but access to state-only funded DDA services is limited by availability of funding.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	9000
Year 2	9000
Year 3	9000
Year 4	9000
Year 5	9000

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	8000
Year 2	8000
Year 3	8000
Year 4	8000
Year 5	8000

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

◉ **Not applicable. The state does not reserve capacity.**

○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

State regulations stipulate: When there is capacity on a waiver and there is available funding for new waiver participants, DDA will consider any of the following populations in any order:

(a) Priority populations as identified and funded by the legislature.

From time to time the Legislature will direct (when funding is available) DDA to add specific groups of individuals to the waiver program in order to meet identified needs.

An example would be to enroll high school graduates on the appropriate waiver (i.e., appropriate to their specific living situation and support needs) who wish to receive

supported employment services. Other examples include enrolling a) individuals who require the services offered under the Community Protection Waiver, b) individuals when

their Roads to Community Living (MFTP) funding expires, and c) individuals who are ready to move back to the community from an IMD.

(b) Persons DDA has determined to be in immediate risk of ICF/IID admission due to unmet health and safety needs.

(c) Persons identified as a risk to the safety of the community.

(d) Persons currently receiving services through state only funds.

(e) Persons on an HCBS waiver that provides services in excess of what is needed to meet their identified health and welfare needs (i.e., needs can be met on a lesser waiver).

(f) Persons who were previously on an HCBS waiver since April 2004 and lost waiver eligibility due to residing in an institution.

(g) Persons exiting Department of Children, Youth and Families extended foster care or aging out of dependency.

(h) Persons age 20 and younger who are subject to a state court dependency proceeding pursuant to chapter 13.34 RCW or a similar proceeding in tribal court, are receiving extended foster care services, or exited a

dependency or discontinued extended foster care services from the Department of Children, Youth and Families or from a Tribe in Washington State and desire waiver services without reference to the waiver's

capacity.

Sometimes an individual on a DDA HCBS waiver is in need of and elects to receive the level of support available in an institutional setting (as defined below). If the individual remains in the institution for at

least 30 days, then under certain circumstances (see the WAC language below) the individual is terminated from her/his/their waiver. At the time the individual is able to return to a community setting, she/he/

they is placed on the appropriate waiver in order to receive the support necessary to support her/him/them in the community.

Per WAC 388-845-0060(1) concerning termination of waiver enrollment, a waiver participant residing in an institution may be terminated from a waiver under the following circumstances.

(I) She/he/they is residing in a hospital, jail, prison, nursing facility, ICF/IID, or other institution and remains in residence at least one full calendar month, and is still in residence: and there is no

immediate plan for the waiver participant to return to the community

(i) At the end of that full calendar month; or

(ii) At the end of the twelfth month following the effective date of their current person-centered service plan, as described in WAC 388-845-3060; or

(iii) At the end of the waiver (fiscal) year, whichever date occurs first.

The State follows State rules (WAC 388-845-0045) in the operation of the waiver application process and these rules do not prescribe a priority to one criteria over another criteria. State reviews all requests for waiver enrollment and selects those from among priority groups first for enrollment and then considers all other eligible applicants. Capacity and funding for the waiver will limit the State’s ability to enroll all eligible applicants.

The standardized DDA Assessment and the requesting Case/Resource Manager document the immediate risk factors due

to unmet health and safety needs in the participant's assessment and waiver request. The standardized DDA Assessment and the Regional Community Protection Committee document the risk factors that indicate a person is a risk to the safety of the community in the participant's assessment and waiver request.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Children with adoption assistance, foster care, or guardianship care under title IV-E (42 CFR 435.145).

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**

(*select one*):

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ◉ **Other standard included under the state plan**

Specify:

A client eligible for home and community based (HCBS) waiver services authorized by the developmental disabilities administration (DDA) under WAC 182-515-1513 must pay toward the cost of care and room and board as specified in WAC 182-515-1514.
DDA determines how much a client must pay toward the cost of care for home and community based (HCBS) waiver services authorized by DDA when the client is living at home or in an alternate living facility. Post eligibility treatment of income, personal needs allowance, allowable deductions for earned income, guardianship fees, child support, needs allowance for a spouse or dependent, medical expenses and other deductions are specified in WAC 182-515-1514.

- ○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The following formula is used to determine the needs allowance:**

Specify:

- ○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- ◉ **Not Applicable**
- ○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- **SSI standard**
- **Optional state supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:
- **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant,*

not applicable must be selected.

- ○ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- ◉ **The following formula is used to determine the needs allowance:**

Specify formula:

A client eligible for home and community based (HCBS) waiver services authorized by the developmental disabilities administration (DDA) under WAC 182-515-1513 must pay toward the cost of care and room and board as specified in WAC 182-515-1514.
DDA determines how much a client must pay toward the cost of care for home and community based (HCBS) waiver services authorized by DDA when the client is living at home or in an alternate living facility. Post eligibility treatment of income, personal needs allowance, allowable deductions for earned income, guardianship fees, child support, needs allowance for a spouse or dependent, medical expenses and other deductions are specified in WAC 182-515-1514.

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The state does not establish reasonable limits.**
○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ◉ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

Specify the entity:

○ **Other**
Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Regional DDA Case/Resource Managers and Regional DDA Social Service Specialists are the only individuals who perform the initial evaluations of level of care prior to placement onto the waiver. In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory waiver training prior to completing any evaluations.

DDA Case/Resource Manager
Minimum Qualifications:
A Bachelor's degree in social sciences, social services, human services, behavioral sciences or an allied field and two years of experience providing social services to people with intellectual or developmental disabilities. OR
6 years of experience in providing social services to people with intellectual or developmental disabilities. OR
Satisfactory completion of 12 months as a Case Resource Manager Trainee. OR
Equivalent experience/education.

Social Service Specialist
Minimum Qualifications
A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience.
OR
A Bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years of social service experience.
OR
Seven years of professional experience and/or related education in providing social services to people with intellectual or developmental disabilities.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The Supports Intensity Scale-Adult (SIS-A) 2nd Edition is a nationally normed instrument developed by the American Association on Intellectual and Developmental Disabilities used to determine ICF/IID Level of Care for individuals aged 16 and over. The SIS-A is a multidimensional scale designed to determine the pattern and intensity of individual's support needs. The SIS-A was designed to a) assess support needs b) determine the intensity of needed supports c) monitor progress and d) evaluate outcomes of adults with intellectual disabilities and related developmental disabilities. The Supports Intensity Scale evaluates individuals using the following subscales:

(1) Home Living activities;
(2) Community Living activities;
(3) Health and safety activities;
(4) Lifelong Learning activities;
(5) Work activities;
(6) Social activities; and
(7) Advocacy activities.

DDA added two additional scales that include:

- Exceptional Medical Supports Activities
- Exceptional Behavioral Supports Activities

The state of Washington has adapted an ICF/IID Level of Care tool that was originally used to assess individuals through age 12 to assess individuals through age 15. This assessment consists of 18 items, all of which are used to determine ICF/IID Level of Care.

Support needs are assessed in the following areas:

A. Activities of Daily Living
B. Instrumental Activities of Daily Living
C. Family Supports
D. Safety & Interactions
E. Peer Relationships

ICF/IID Level of Care as described in Washington Administrative Code (WAC) Chapter 388-828-4400 for adults (16 years of age and older) and Chapter 388-828-3080 for children (birth through 15 years of age).

How does DDA determine my score for ICF/IID Level of Care if I am age birth through fifteen years old? DDA determines your ICF/IID Level of Care score by adding your acuity scores for each question in the ICF/IID Level of Care Assessment for Children.

How does DDA determine if I meet the eligibility requirements for ICF/IID Level of care if I am age birth through 15 years old? DDA determines you to be eligible for ICF/IID Level of care when you meet at least one of the following:

1. You are age birth through five years old and the total of your acuity scores is five or more; or
2. You are age six through fifteen years old and the total of your acuity scores is seven or more.

How does DDA determine if you meet the eligibility requirements for ICF/IID level-of-care if you are age sixteen or older? If you are age sixteen or older, DDA determines you to be eligible for ICF/IID level-of-care from your SIS scores. Eligibility for ICF/IID level-of-care requires that your scores meet at least one of the following:

(1) You have a percentile rank over nine percent for three or more of the six subscales in the SIS support needs scale;
(2) You have a percentile rank over twenty-five percent for two or more of the six subscales in the SIS support needs scale;
(3) You have a percentile rank over fifty percent in at least one of the six subscales in the SIS support needs scale;
(4) You have a support score of one or two for any of the questions listed in the SIS exceptional medical support needs scale;
(5) You have a support score of one or two for at least one of the following items in the SIS exceptional behavior support needs scale:

(a) Prevention of assaults or injuries to others;
(b) Prevention of property destruction (e.g., fire setting, breaking furniture);
(c) Prevention of self-injury;
(d) Prevention of PICA (ingestion of inedible substances);

(e) Prevention of suicide attempts;
(f) Prevention of sexual aggression; or
(g) Prevention of wandering.
(6) You have a support score of two for any of the questions listed in the SIS exceptional behavior support needs scale; or
(7) You meet or exceed any of the qualifying scores for one or more of the following SIS questions:

Question # of SIS Support needs scale	Text of question	Your score for "Type of support" is	And your score for "Frequency of support" is
A1	Bathing and taking care of personal hygiene and grooming needs	2 or more	4
		3 or more	2
A2	Dressing	2 or more	4
		3 or more	2
A3	Using the toilet	2 or more	4
		3 or more	2
A4	Preparing food	2 or more	4
		3 or more	2
A5	Eating food	2 or more	4
		3 or more	2
A6	Taking care of clothes, including laundering	2 or more	2 or more
		3 or more	1
A7	Housekeeping and cleaning	2 or more	2 or more
		3 or more	1
B6	Shopping and purchasing goods and services	2 or more	2 or more
		3 or more	1
C1	Taking medications	2 or more	4
		3 or more	2
C2	Ambulating and moving about	2 or more	4
		3 or more	2
C3	Avoiding health and safety hazards	2 or more	3 or more
		3 or more	2
C6	Maintaining a nutritious diet	2 or more	2 or more
		3 or more	1
C8	Maintaining emotional well-being	2 or more	3 or more
		3 or more	2
D1	Learning and using problem solving strategies	2 or more	3 or more
		3 or more	2
D5	Learning self-management strategies	2 or more	3 or more
		3 or more	2
F1	Using appropriate social skills	2 or more	3 or more
		3 or more	2
G3	Managing money and personal finances	2 or more	2 or more
		3 or more	1

e. Level of Care Instrument(s). Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Level of Care Assessment is completed by designated trained DDA staff (Case/Resource Managers or Social Service Specialists) who are the only individuals who perform these assessments. Please see B-6.d. for a description of the Level of Care criteria.

The qualified and trained Case/Resource Manager/Social Services Specialist completes the SIS-A or the ICF/IID Level of Care Assessment for Children, at least annually by obtaining information about the person's support needs via a face-to-face in-person or virtual interview with the person and one or more respondents who know the person well. The waiver participant decides whether the interview will be in person, virtually, or over the phone and the waiver participant also determines who will be invited for the interview. The in-person method is the default option for waiver participants. The Case/Resource Manager is responsible for verifying that the waiver participant has the capability of responding to a virtual or telephone interview if that method of interview is desired by the waiver participant. Included in this preparation for a virtual or telephone assessment is whether the waiver participant has appropriate electronic equipment and any needed assistance to operate the equipment to ensure a successful virtual assessment if that is the choice of the waiver participant.

The inter-rate reliability (IRR) level of care is a 1:1 evaluation of a Case/Resource Manager's ability to correctly administer the DDA Assessment. The level of care is one product of the DDA Assessment. DDA CARE Specialist staff, DDA's subject matter experts on the DDA Assessment, observe each new Case/Resource Manager administering a DDA Assessment interview within 30 days of completing training to become certified. Waiver participants must provide permission for this staff to observe the Case/Resource Manager in-person or virtually. They will be observed one year later by a CARE Specialist to ensure competency in administering the assessment and to remain certified. Once the Case/Resource Manager is certified they must attend yearly training provided by CARE Specialists to maintain their certification.

The Case/Resource Manager and CARE Specialist independently complete separate assessments and the CARE Specialist compares the results to ensure that the Case/Resource Manager's determination of ICF/IID eligibility is consistent with the CARE Specialist. Additionally, the CARE Specialist evaluates the Case/Resource Manager's interview skills, person centered skills and knowledge of the DDA Assessment.

All LOCs are not IRR LOCs as this would not be practical nor warranted. On an annual basis, CARE Specialist's will review at least one assessment per Case/Resource Manager to ensure LOC accuracy and consistency throughout the assessment. The annual sample of IRR LOCs performed for the 500+ Case/Resource Managers is a statistically valid sample size for the universe of all participants receiving paid services (45,000 participants receiving paid services requires a sample size of 380 for a confidence level of 95% with a margin of error of +/- 5% according to Raosoft).

When a Case/Resource Manager's assessment is deemed to be significantly variant from the CARE Specialist's assessment, the Case/Resource Manager must receive additional training and possibly require re-certification.

State believes this performance measure is a valid, reliable, and a sufficient measure of Case/Resource Managers' ability to consistently conduct a DDA Assessment and produce a consistent and reliable LOC.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

o Regional management is responsible for ensuring that DDA staff complete annual evaluations.
o Assessment data is monitored monthly by regional management and HQ Program Managers and Quality Assurance staff to ensure compliance.
o Waiver Specialists review Assessment Activity Reports that are generated monthly by HQ and distributed to CRMs to promote completing assessment timely.
o DDA assessors set personal tickler systems.
o Annual, monthly and quarterly file reviews track compliance. Ternary reviews are completed by supervisors. Annual reviews are completed by the Quality Compliance Coordinators (QCC).
o The DDA assessment (on the CARE platform) tracks timeliness of reevaluations. Case Resource Managers, Social Service Specialists, DDA supervisors and DDA executive management all monitor these reports.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations will be maintained for a minimum of ten (10) years. Paper copies are available in the client file, which is maintained in the regional office. The electronic evaluation is on an electronic platform and can be viewed remotely from any DDA office in the state.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

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

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

Performance Measure:
B.a.1. # & % of all waiver applicants for whom there is a reasonable indication that services may be needed in future (RISNF) who received an evaluation for LOC prior to a completed request for enrollment N = # of wvr apps for whom there is (RISNF) who received an eval for LOC prior to a cmpltd request for enrllmt D = All wvr apps for whom there is RISNF

Data Source (Select one):
Other
If 'Other' is selected, specify:
CARE system.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:
B.c.1. Number & percent of inter-rater reliability (IRR) LOC determinations made where LOC processes and instruments described in approved waiver were accurately applied. N = Number of IRR LOC determinations made where LOC processes and instruments described in approved waiver were accurately applied. D = IRR LOC determinations reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Joint Requirements Planning (JRP) Team within DDA.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Joint Requirements Planning (JRP) Team within DDA.	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

B.a.1.
Administrative data is collected in real time in DDA's Comprehensive Assessment Reporting and Evaluation (CARE) system, which is the database of record for client information. Waiver enrollment requests are processed in CARE, which will not allow completion of the request without a completed level of care assessment. A report based on data in CARE is used to identify all applicants for waiver enrollment for whom an evaluation for LOC was completed prior to a completed request for waiver enrollment and to identify all waiver enrollment applicants.

B.c.1. When new Case/Resource Managers are hired, they go through five weeks of training which includes extensive training on the use and administration of the LOC assessment, mission, vision and values, person-centered practices, programs and services training specific to DDA services, and in-depth online training about policy and procedures. Within 30 working days of completion of this intensive five weeks of required training, CARE Specialists perform a 1:1 evaluation of new Case/Resource Managers to ensure that the LOC assessment is administered correctly. In addition, CARE Specialists conduct an 1:1 evaluation of all new Case/Resource Managers after their first year to ensure that they maintain their skills in administering the LOC assessment in a consistent and reliable manner. During the initial and one year 1:1 evaluations CARE Specialists accompany Case/Resource Managers on a LOC assessment interview. The Case/Resource Manager conducts the assessment interview and both the CARE Specialist and Case/Resource Manager independently complete separate LOC assessments based on the information provided in the interview. The Case/Resource Manager's LOC assessment is then compared to the CARE Specialist's LOC assessment to ensure that the Case/Resource Manager's determination of ICF/IID LOC eligibility is consistent with that of the CARE Specialist. CARE Specialists also evaluate the Case/Resource Manager's interview skills in the following areas: introduction to the tool, mechanics and style of the interview process, and understanding of scoring.
All LOCs are not IRR LOCs as this would not be practical nor warranted. On an annual basis, CARE Specialist's will review at least one assessment per Case/Resource Manager to ensure LOC accuracy and consistency throughout the assessment. The annual sample of IRR LOCs performed for the 500+ Case/Resource Managers is a statistically valid sample size for the universe of all participants receiving paid services (45,000 participants receiving paid services requires a sample size of 380 for a confidence level of 95% with a margin of error of +/- 5% according to Raosoft).

b. Methods for Remediation/Fixing Individual Problems

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

State tracks capacity of participants in the waiver twice weekly in a report labeled 'Waiver Capacity Status' and distributes this report to Waiver Specialists and Regional Field Service Administrators. Real time data for this report comes from two stand-alone production reports: CARE 1225 DDA Assessment Activity Report and the CARE 1010 Boyle Waiver Enrollment Detail Report.
B.a.1 & B.c.1: Case/Resource Managers whose initial LOC evaluation or LOC reevaluation reveals that the LOC tools were inappropriately applied receive additional training by the CARE Specialist and the Case/Resource Manager's Supervisor is notified. In addition, all errors in the assessment must be corrected by the Case/Resource Manager prior to moving the assessment to current status in the CARE system.
If a participant is found ineligible for the waiver when the LOC criteria is correctly applied, the participant is terminated from the waiver with appropriate notice as required by WAC 388-845-0065. The Case/Resource Manager will explore non-waiver services with the participant that may be available according to WAC 388-825-057.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DDA Case/Resource Manager (CRM) or DDA Social Service Specialist (SSS) discuss the alternatives available as a part of the annual assessment process. The individual and/or their legal representative sign the Voluntary Participation Statement to indicate their choice of community based services or ICF/IID services.

The State offers all individuals an institutional option. The Case Resource Manager provides this information to all individuals and documents this in the Voluntary Participation Form which the client signs.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

A hard or electronic copy of the Voluntary Participation Statement that contains the signatures is maintained in the client record in the local DDA field service office.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Service access to Limited English Proficient individuals is ensured by providing bilingual staff or contracted interpreter services at no cost to the participant. Program materials are translated into the participant's primary language. Outreach materials explaining the program are translated into eight different languages.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Respite		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Speech, Hearing and Language Services		
Other Service	Assistive Technology		
Other Service	Community Engagement		
Other Service	Environmental Adaptations		
Other Service	Life Skills		
Other Service	Nurse Delegation		
Other Service	Peer Mentoring		
Other Service	Person-Centered Plan Facilitation		
Other Service	Remote Supports		
Other Service	Risk Assessment		
Other Service	Skilled Nursing		
Other Service	Specialized Clothing		
Other Service	Specialized Equipment and Supplies		
Other Service	Specialized Habilitation		
Other Service	Stabilization Services - Crisis Diversion Bed		
Other Service	Stabilization Services - Life Skills		
Other Service	Stabilization Services - Specialized Habilitation		
Other Service	Stabilization Services - Staff/Family Consultation		
Other Service	Staff/Family Consultation		
Other Service	Supported Parenting		
Other Service	Therapeutic Adaptations		
Other Service	Transportation		
Other Service	Vehicle Modifications		
Other Service	Wellness Education		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Short-term intermittent relief for persons who normally provide care for and live with the waiver participant. Personal care is incidental to the delivery of this service.

The following identify waiver participants who are eligible to receive respite care:

1) The waiver participant lives in her/his/their family home and no person living with her/him/them is contracted by DSHS to provide the waiver participant with a service; or
2) The waiver participant lives with a family member who is her/his/their primary caregiver and who is a contracted provider by DSHS to provide her/him/them with a service; or
3) The waiver participant lives with a caregiver who is contracted by DDA to provide supports as:
(a) A contracted companion home provider; or
(b) A licensed children's foster home provider.

Someone who lives with the waiver participant may be the respite provider as long as she/he/they is not the person who normally provides care for the individual and is not contracted to provide any other DSHS paid service to the individual.

Respite care can be provided in the following locations:
(a) waiver participant's home or place of residence;
(b) Relative's home;
(c) Licensed children's foster home;
(d) Licensed, contracted and DDA certified group home;
(e) Licensed assisted living facility contracted as an adult residential center;
(f) Adult residential rehabilitation center;
(g) Licensed and contracted adult family home;
(h) Children's licensed group home, licensed staffed residential home, or licensed childcare center;
(i) Other community settings such as camp, senior center, community organizations, informal clubs, libraries or adult day care center.

Additionally, the waiver participant's respite care provider may take her/him/them into the community while providing respite services.

Respite Service will not duplicate the services available under the State Plan.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

• The Consumer Directed Employer (CDE) is the employer of all individual providers of waiver respite and State-Plan personal care under the Community First Choice program. As the employer of individual providers, the CDE will
oversee and track training, certification and background checks. SEIU and the Training Partnership will continue to provide the required training for all individual providers.
• Waiver participants have been notified and will continue to be messaged concerning the transition to the CDE.
• The role of the CDE is a provider type for waiver respite services by individual providers and State Plan personal care by individual providers for the Community First Choice program.
• The CDE is a §1915(c) paid respite waiver service provider.
• The Consumer Directed Employer will oversee and track training, certification and background checks for CDE Individual Providers of Respite.
• The Consumer Directed Employer staff will assist clients and individual providers with using the state-maintained Carina/Home Care Referral Registry (https://www.carinacare.com).
• Qualifications for individual respite providers under the Consumer Directed Employer are the same as the qualifications in the approved waivers. All current qualified providers will meet requirements to be hired by the Consumer
Directed Employer.
• The respite provider type individual provider will be phased out once the implementation of the CDE in complete.

ARPA funds may be expended for respite services (intellectual/developmental disability summer programs & caregiver/provider training which is already included in service rate methodology in Appendix I-2-a).

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

1) Clinical and support needs for respite care are identified and documented in the waiver participant's DDA person-centered service plan (PCSP);
2) The IFS Waiver annual allocation will determine how much respite the waiver participant is authorized to receive.

3) Respite cannot replace:
(a) Day care while her/his/their parent or guardian is at work.
4) Respite care providers have the following limitations and requirements:
(a) If respite is provided in a private home, the home must be licensed unless it is the waiver participant's home or the home of a relative of specified degree per WAC 388-825-345 (concerning "related" providers that are exempt from licensing);
(b) The respite care provider cannot be the spouse of the caregiver receiving respite if the spouse and the caregiver reside in the same residence; and
(c) If the waiver participant receives respite from a provider who requires licensure, the respite care services are limited to those age-specific services contained in the provider's license.
5) The caregiver may not provide:
(a) other DDA services for the individual participant or other persons during her/his/their respite care hours; or
(b) DDA paid services to other persons during your respite care hours.
6) If the waiver participant's personal care provider is her/his/their parent, the parent provider will not be paid to provide respite services to any client in the same month that the waiver participant receives respite services.
7) If the waiver participant's personal care provider is the parent and the individual lives in the parent's adult family home, the individual may not receive respite.
8) DDA may not pay for any fees associated with the respite care; for example, membership fees at a recreational facility, or insurance fees.
9) If the waiver participant requires respite care from a licensed practical nurse (LPN) or a registered nurse(RN), respite services may be authorized using an LPN or RN. Respite services using a LPN or RN are limited to the dollar limits of the waiver participant's annual IFS allocation.
10) Service under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

The use of respite in any given month is determined by the individual based on her/his/their need that month and the amount of funding available to them annually (as detailed in Appendix C-4-a).

Rates for individual providers and agencies are based upon rates provided to personal care providers. Rates for community-based settings such as senior centers and summer camps are based upon the rates charged to the public. All payments are made directly by the single state agency to the provider of service.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	RN respite
Agency	Child Day Care Center
Agency	Group Care Home
Individual	individual Provider

Provider Category	Provider Type Title
Agency	State Operated Living Alternatives (SOLA)
Agency	Home Care Agency
Agency	Adult Residential Care Facility
Agency	Community Centers
Agency	Adult Residential Treatment Facility
Agency	Consumer Directed Employer of Respite Individual Providers
Agency	Adult Day Care Center
Agency	Parks and Recreation Programs
Agency	Child Care Center
Agency	Senior Centers
Agency	Child Foster Group Care Home
Agency	Child Foster Care Home
Agency	Summer Programs
Agency	Home Health Agency
Agency	Licensed Staffed Residential Programs
Agency	Enhanced Adult Residential Care
Individual	LPN respite
Individual	Certified Nursing Assistant
Agency	Adult Family Home
Agency	RN respite
Agency	LPN respite

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

RN respite

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC DOH

Certificate *(specify):*

Other Standard *(specify):*

Contract standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Child Day Care Center

Provider Qualifications

License *(specify):*

Chapter 170-295 WAC (Department of Early Learning administrative code concerning minimum licensing requirements for child day care centers)
Chapter 170-297 WAC (Department of Early Learning administrative code concerning minimum licensing requirements for school-age child care)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Group Care Home

Provider Qualifications

License *(specify):*

An agency, other than a foster-family home, which is maintained and operated for the care of a group of children on a twenty-four hour basis and licensed under chapter 110-145 WAC.

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 2 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

individual Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• WAC 388-825-320 (DSHS administrative code concerning how someone becomes an individual provider)
• WAC 388-825-340 (concerning what is required for a provider to provide respite or residential service in their home)
• WAC 388-825-345 (concerning what related providers are exempt from licensing)
• WAC 388-825-355 (concerning educational requirements for individuals providing respite services)
• WAC 388-825-325 (concerning required skills and abilities for individuals and agencies contracted to provide respite care)
• WAC 388-825-365 (concerning reporting abuse, neglect, exploitation or financial exploitation)
• Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

State Operated Living Alternatives (SOLA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 388-101 and 388-101D WAC (ALTSA/DDA administrative code concerning certified community residential services and support)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 2 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Chapter 70.127 RCW (State law concerning licensing of home health, hospice, and home care agencies)

WAC 246-335 Part 1 (Requirements for in-home services agencies licensed to provide home health, home care, hospice, and hospice care center services)

WAC 246-335-020 (Department of Health licensing requirements for agencies that provide home health, home care, hospice, and hospice care center services)

Certificate *(specify):*

Other Standard *(specify):*

WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, training and continuing education for individual providers and home care agency providers)

A home care agency provides nonmedical services and assistance (e.g., respite care) to ill, disabled or vulnerable individuasl to enable them to remain in their residence.

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Residential Care Facility

Provider Qualifications

License *(specify):*

Chapter 388-78A WAC (DSHS administrative code concerning Assisted Living Facility licensing rules)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Community Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications for respite in the community.

34. a. The Contractor shall be licensed, registered, and certified as is required by law.

b. Community settings providing respite care must meet the regulations governing their business or activity.

c. Contractors offered services must be published on website and include:
(1) Identified number of service hours being provided in your program/class/event including days/date and start and end time;
(2) Identify activities that will occur during program/class/event; and
(3) Published Fee schedule.

d. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)
WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Residential Treatment Facility

Provider Qualifications

License *(specify):*

Chapter 246-337 WAC (DSHS administrative code concerning Adult Residential Treatment Facility)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Consumer Directed Employer of Respite Individual Providers

Provider Qualifications

License *(specify):*

Current Washington State business license

Certificate *(specify):*

Other Standard *(specify):*

Consumer Directed Employer: Meet qualifications outlined in RCW 74.39A.500
Individual Respite providers of the CDE: must complete the DSHS background check requirements outlined in WAC 388-71-0510 and the training/certification requirements described in WAC 388-71-0520 and 0523.
Individual Respite providers will have the skills and characteristics the participant (as the co-employer) has deemed important to meet their person-centered service plan PSCP) needs.
Individuals who provide transportation must have a valid driver license and meet state requirements for insurance coverage listed in RCW 4.30.
• Qualifications for individual respite providers under the Consumer Directed Employer are the same as the qualifications in the approved waivers. All current qualified providers will meet requirements to be hired by the Consumer Directed Employer.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participants use their co-employer authority to verify that providers have the necessary skills and characteristics to meet their unique respite needs as identified in the person-centered service plan, and provide training on their PCSP needs outside of Basic Training and Continuing Education requirements by state law.
The Consumer Directed Employer will verify providers meet the following qualifications:
a. Cleared background checks as required by state law;
b. Completed training and certification as required by state law; and
c. Completed continuing education credits as stipulated in state law in order to continue to provide respite services.
Aging and Long-Term Support Administration, as an operating agency of the Medicaid agency, will complete monitoring of the Consumer Directed Employer.

Frequency of Verification:

An initial background check is completed for respite providers. If there is reasonable cause to suspect that the provider has been arrested or convicted of a disqualifying crime, the CDE must have the provider complete a new background check.
Annually the Consumer Directed Employer will be monitored by the Aging and Long-Term Support Administration to verify compliance standards.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Day Care Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications for respite in the community.

34. a. The Contractor shall be licensed, registered, and certified as is required by law.

b. Community settings providing respite care must meet the regulations governing their business or activity.

c. Contractors offered services must be published on website and include:
(1) Identified number of service hours being provided in your program/class/event including days/date and start and end time;
(2) Identify activities that will occur during program/class/event; and
(3) Published Fee schedule.

d. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)
WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Parks and Recreation Programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications for respite in the community.

34. a. The Contractor shall be licensed, registered, and certified as is required by law.

b. Community settings providing respite care must meet the regulations governing their business or activity.

c. Contractors offered services must be published on website and include:
(1) Identified number of service hours being provided in your program/class/event including days/date and start and end time;
(2) Identify activities that will occur during program/class/event; and
(3) Published Fee schedule.

d. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)
WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Child Care Center

Provider Qualifications

License *(specify):*

Chapter 170-295 WAC (Department of Early Learning administrative code concerning child care center minimum licensing requirements)
Chapter 170-297 WAC (Department of Early Learning administrative code concerning school-age child care minimum licensing requirements)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Senior Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications for respite in the community.

34. a. The Contractor shall be licensed, registered, and certified as is required by law.

b. Community settings providing respite care must meet the regulations governing their business or activity.

c. Contractors offered services must be published on website and include:
(1) Identified number of service hours being provided in your program/class/event including days/date and start and end time;
(2) Identify activities that will occur during program/class/event; and
(3) Published Fee schedule.

d. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)
WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Child Foster Group Care Home

Provider Qualifications

License *(specify):*

Chapter 388-145 WAC (DSHS administrative code concerning licensing requirements for child foster homes, staffed residential homes, group residential facilities, and child-placing agencies)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Child Foster Care Home

Provider Qualifications

License *(specify):*

A private home licensed under chapter 110-148 WAC to provide twenty-four hour care to children.

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Summer Programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Summer Camps

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications for respite in the community.

34. a. The Contractor shall be licensed, registered, and certified as is required by law.

b. Community settings providing respite care must meet the regulations governing their business or activity.

c. Contractors offered services must be published on website and include:
(1) Identified number of service hours being provided in your program/class/event including days/date and start and end time;
(2) Identify activities that will occur during program/class/event; and
(3) Published Fee schedule.

d. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)
WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Chapter 70.127 RCW (State law concerning licensing of home health, hospice, and home care agencies)

WAC 246-335 Part 1 (Requirements for in-home services agencies licensed to provide home health, home care, hospice, and hospice care center services)

WAC 246-335-020 (Department of Health licensing requirements for agencies that provide home health, home care, hospice, and hospice care center services)

Certificate *(specify):*

Other Standard *(specify):*

WAC 388-71-0500 through WAC 388-71-0556 (DSHS administrative code concerning individual provider and home care agency provider qualifications)

WAC 388-71-05670 through WAC 388-71-05799 (DSHS administrative code concerning orientation, training and continuing education for individual providers and home care agency providers)

A home health agency provides medical and nonmedical services to ill, disabled or vulnerable individuals residing in temporary or permanent residences.

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Staffed Residential Programs

Provider Qualifications

License *(specify):*

A licensed facility under chapter 110-145 WAC that provides twenty-four care to six or fewer children who require more supervision than can be provided in a foster home.

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Enhanced Adult Residential Care

Provider Qualifications

License *(specify):*

Chapter 388-78A WAC (DSHS administrative code concerning assisted living licensing rules)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every eighteen months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

LPN respite

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC DOH

Certificate *(specify):*

Other Standard *(specify):*

Contract standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Certified Nursing Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-841 WAC (Department of Health administrative code conerning nursing assistants)

Other Standard *(specify):*

WAC 388-825-320 (DSHS administrative code concerning how someone becomes an individual provider)
WAC 388-825-340 (concerning what is required for a provider to provide respite or residential service in their home)
WAC 388-825-345 (concerning what related providers are exempt from licensing)
WAC 388-825-355 (concerning educational requirements for individuals providing respite services)
WAC 388-825-325 (concerning required skills and abilities for individuals and agencies contracted to provide respite care)
WAC 388-825-365 (concerning reporting abuse, neglect, exploitation or financial exploitation)
Chapter 246-841 WAC (Department of Health-DOH- administrative code concerning nursing assistants)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications for individual providers.

a. The Contractor shall maintain all necessary licenses, registrations, and certifications as required by law. The Contractor agrees not to perform any task requiring a registration, certificate or license unless he/she is registered, certified or licensed to do so or is a member of the client's immediate family or is performing self-directed health care tasks. See RCW 18.679, 18.88A and 74.39 for laws related to nursing care, Registered Nurse Delegation, and self-directed health care tasks, respectively.

b. If the Contractors is providing Nurse Delegation Services, the Contractor must:

(1) Complete the Nurse Delegation for Nursing Assistants course and pass the competency test;

(2) Be a nursing assistant currently registered or certified;

(3) For Nursing Assistant Registereds, successfully complete Revised fundamentals of Caregiving, or
Modified Fundamentals of Caregiving; and

(4) Complete all Nurse Delegation training before performing any delegated task.

c. Prohibition of ALTSA/DDA employees contracting with DSHS to provide Individual Provider Services to DSHS long-term care clients.

If you are currently an Employee of ALTSA/DDA either with the
Developmental Disabilities Administration, Residential Care Services, or Home and Community services, or become an
employee of the same during the course of the period of this contract, you are considered disqualified and
DSHS will terminate your contract for convenience.

d. The Contractor shall meet all training requirements in WAC 388-71. DSHS shall supply the Contractor with training requirements and time frames for completion.

The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for

respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer
programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Family Home

Provider Qualifications

License *(specify):*

Chapter 388-76 WAC (DSHS administrative code concerning adult family homes minimum licensing requirements)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1615 Who are qualified providers of respite care?

Providers of respite care can be any of the following individuals or agencies contracted with DDA for respite
care:
(1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
(2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
(3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes
and foster group care homes;
(4) Licensed and contracted adult family homes;
(5) Licensed and contracted adult residential care facilities;
(6) Licensed and contracted adult residential treatment facilities under chapter 246-337 WAC;
(7) Licensed child care centers under chapter 170-295 WAC;
(8) Licensed child day care centers under chapter 170-295 WAC;
(9) Adult day care providers under chapter 388-71 WAC contracted with DDA;
(10) Certified provider under chapter 388-101 WAC when respite is provided within the DDA contract for
certified residential services; or
(11) Other DDA contracted providers such as community center, senior center, parks and recreation, summer programs.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

RN respite

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC DOH

Certificate *(specify):*

Other Standard *(specify):*

Contract standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

LPN respite

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC DOH

Certificate *(specify):*

Other Standard *(specify):*

Contract standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Occupational therapy services are available through the waiver for adults age 21 and over when the service is is not covered due to medical necessity, but is determined necessary for remedial benefit or is in excess (number of visits) of the state plan benefit.

This waiver service will in no way impede a child's or young adult's access to services to which they are entitled under EPSDT.

Before this therapy is offered as a waiver service, DSHS Form 13-734, Documentation of First Use of Medicaid Benefits, is used to document that clients have first accessed services to which they are entitled through the State Plan (including EPSDT).

State law stipulates:
"Occupational therapy" is the scientifically based use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process in order to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation. Specific occupational therapy services include but are not limited to:
• Using specifically designed activities and exercises to enhance neuro developmental, cognitive, perceptual motor, sensory integrative, and psychomotor functioning;
• administering and interpreting tests such as manual muscle and sensory integration;
• teaching daily living skills;
• developing prevocational skills and play and vocational capabilities;
• designing, fabricating, or applying selected orthotic and prosthetic devices or selected adaptive equipment; and
• adapting environments for the handicapped. These services are provided individually, in groups, or through social systems.(An example of OT provided through a social system would be therapy provided in the home environment with
the involvement of family members or providers. A goal would be to incorporate therapeutic activities into the individuals natural household routine.)

State law stipulates:
Occupational Therapy services must be provided by a person licensed to provide Occupational Therapy in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR §440.110 (concerning physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders).

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive. Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health

and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.

The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant’s video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant’s Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client’s file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

• The need for Occupational therapy is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan. OT will decrease as participant goals are achieved and methods of providing ongoing support through natural routines are determined successful.

• The services under the waiver are limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

• DDA does not pay for treatment determined by DSHS to be experimental.

• DDA and the treating professional determine the need for and amount of service an individual can receive:

o DDA reserves the right to require a second opinion from a department selected provider.

o State Plan benefits are limited to one Occupational Therapy evaluation at beginning of service and one evaluation at discharge per year and 24 units of Occupational Therapy (which equals approximately 6 hours) per year and up to an additional 24 units of Occupational Therapy per year with expedited prior authorization from the Health Care Authority. State Plan provides a process for limitation extension regarding the scope, amount, duration and frequency of the therapy when requested by the provider. Criteria considered by the Health Care Authority and MCO for limitation extension include: the level of improvement the client has shown to date related to the requested therapy and the reasonably calculated probability of continued improvement if the requested therapy is extended; and the reasonably calculated probability the client's condition will worsen if the requested therapy is not extended.

o The Provider One payment system enforces that Medicaid Benefits to which they are entitled are first accessed through the State Plan.

o This waiver service is only provided to individuals age 21 and over. All medically necessary Occupational Therapy services for children under age 21 are covered in the State Plan pursuant to the EPSDT benefit.

o The dollar limitations for the waiver participant's IFS Waiver annual allocation limit the amount of assistive technology service she/he/they is authorized to receive as indicated in Appendix C-4.a.

Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Occupational Therapy

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

RCW 18.59.050 (State law concerning licensure requirements for occupational therapists)

Chapter 246-847 WAC (Department of Health administrative code concerning requiremetns for occupational therapists)

Certificate *(specify):*

Other Standard *(specify):*

RCW 18.598.060 (State law concerning examination requirements for occupational therapists)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

2. Qualifications

a. The Contractor shall be licensed, registered, and certified as is required by law.

b. Maintain a Core Provider Agreement with the Health Care Authority, which is the state Medicaid agency,
thus deeming you a Medicaid eligible provider.

Washington Administrative Code (WAC)

WAC 388-845-1010 Who is a qualified provider of extended state plan services?

Providers of extended state plan services must be certified, registered or licensed therapists as required by
law and contracted with DDA for the therapy they are providing.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Occupational Therapy

Provider Qualifications

License *(specify):*

RCW 18.59.050 (State law concerning licensure requirements for occupational therapists)

Chapter 246-847 WAC (Department of Health administrative code concerning requirements for occupational therapists)

Certificate *(specify):*

Other Standard *(specify):*

RCW 18.598.060 (State law concerning examination requirements for occupational therapists)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

2. Qualifications

a. The Contractor shall be licensed, registered, and certified as is required by law.

b. Maintain a Core Provider Agreement with the Health Care Authority, which is the state Medicaid agency,
thus deeming you a Medicaid eligible provider.

Washington Administrative Code (WAC)

WAC 388-845-1010 Who is a qualified provider of extended state plan services?

Providers of extended state plan services must be certified, registered or licensed therapists as required by
law and contracted with DDA for the therapy they are providing.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Physical therapy is available under the waiver for adults age 21 and over when the service is not covered due to medical necessity, but is determined necessary for remedial benefit or is in excess (number of visits) of the state plan benefit. Before this therapy is offered as a waiver service, DSHS Form 13-734, Documentation of First Use of Medicaid Benefits, is used to document that clients have first accessed services to which they are entitled through the State Plan (including EPSDT).

State law stipulates:
Physical Therapy means the treatment of any bodily or mental condition of a person by the use of the physical, chemical, or other properties of heat, cold, air, light, water, electricity, sound massage, and therapeutic exercise, which includes posture and rehabilitation procedures; the performance of tests and measurements of neuromuscular function as an aid to the diagnosis or treatment of any human condition; performance of treatments on the basis of test findings after consultation with and periodic review by an authorized health care practitioner.

State law stipulates:
Physical Therapy services must be provided by a person licensed to provide this service in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.
Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.
State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.
The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic

has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.
Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

• The need for Physical therapy is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan. PT will decrease as participant goals are achieved and methods of providing ongoing support through natural routines are determined successful.
• The services under the waiver are limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.
• DDA does not pay for treatment determined by DSHS to be experimental;
• DDA and the treating professional determine the need for and amount of service an individual can receive:
o DDA reserves the right to require a second opinion from a department-selected provider.
o State Plan benefits are limited to one Physical Therapy evaluation at beginning of service and one evaluation at discharge per year and 24 units of Physical Therapy (which equals approximately 6 hours) per year and up to an additional 24 units of Physical Therapy per year with expedited prior authorization from the Health Care Authority. State Plan provides a process for limitation extension regarding the scope, amount, duration and frequency of the therapy when requested by the provider. Criteria considered by the Health Care Authority and MCO for limitation extension include: the level of improvement the client has shown to date related to the requested therapy and the reasonably calculated probability of continued improvement if the requested therapy is extended; and the reasonably calculated probability the client's condition will worsen if the requested therapy is not extended.
• The Provider One payment system enforces that Medicaid Benefits to which they are entitled are first accessed through the State Plan.
• This waiver service is only provided to individuals age 21 and over. All medically necessary Physical Therapy services for children under age 21 are covered in the State Plan pursuant to the EPSDT benefit.
• The dollar limitations for the waiver participant's IFS Waiver annual allocation limit the amount of this service she/he/they is authorized to receive as indicated in Appendix C-4.a.
Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist
Agency	Physical Therapy

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

RCW 18.74.040 (State law concerning examination for a physical therapy license)

RCW 18.74.040 (State law concerning licensure of physical therapists)

Chapter 2146-915 WAC (Department of Health administrative code concerning requirements for physical therapists)

Certificate *(specify):*

Other Standard *(specify):*

RCW 18.74.030 (State law concerning minimum qualifications to apply for licensure as a physical therapist)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

1. Qualifications

a. The Contractor shall be licensed, registered, and certified as is required by law for professionals whom provide Physical Therapy services in the state of Washington.
b. Maintain a Core Provider Agreement with the Health Care Authority, which is the state Medicaid agency, thus deeming you a Medicaid eligible provider.

Washington Administrative Code (WAC)

WAC 388-845-1010 Who is a qualified provider of extended state plan services?

Providers of extended state plan services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Physical Therapy

Provider Qualifications

License *(specify):*

RCW 18.74.040 (State law concerning examination for a physical therapy license)

RCW 18.74.040 (State law concerning licensure of physical therapists)

Chapter 2146-915 WAC (Department of Health administrative code concerning requirements for physical therapists)

Certificate *(specify):*

Other Standard *(specify):*

RCW 18.74.030 (State law concerning minimum qualifications to apply for licensure as a physical therapist)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

1. Qualifications

a. The Contractor shall be licensed, registered, and certified as is required by law for professionals whom provide Physical Therapy services in the state
of Washington.
b. Maintain a Core Provider Agreement with the Health Care Authority, which is the state Medicaid agency, thus deeming you a Medicaid eligible provider.

Washington Administrative Code (WAC)

WAC 388-845-1010 Who is a qualified provider of extended state plan services?

Providers of extended state plan services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech, Hearing and Language Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Speech, hearing and language services are available through the waiver when a Medicaid provider is not available in the area in which a child or young adult lives or when the service is not covered due to medical necessity, but is determined necessary for remedial benefit. Speech, hearing and language services are services provided to individuals with speech hearing and language disorders by or under the supervision of a speech pathologist or audiologist.

State law stipulates:
"Speech-language pathology" means the application of principles, methods, and procedures related to the development and disorders, whether of organic or nonorganic origin, that impede oral, pharyngeal, or laryngeal sensorimotor competencies and the normal process of human communication including, but not limited to, disorders and related disorders of speech, articulation, fluency, voice, verbal and written language, auditory comprehension, cognition/communication, and the application of augmentative communication treatment and devices for treatment of such disorders

"Audiology" means the application of principles, methods, and procedures related to hearing and the disorders of hearing and to related language and speech disorders, whether of organic or nonorganic origin, peripheral or central, that impede the normal process of human communication including, but not limited to, disorders of auditory sensitivity, acuity, function, processing, or vestibular function, the application of aural habilitation, rehabilitation, and appropriate devices including fitting and dispensing of hearing instruments, and cerumen management to treat such disorders.

State law stipulates:
Speech-language pathology and Audiology services must be provided by a person licensed to provide these services in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR §440.110 (concerning physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders).

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive. Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service

delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.
State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.
The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.
Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

"Speech-language pathology" means the application of principles, methods, and procedures related to the development and disorders, whether of organic or nonorganic origin, that impede oral, pharyngeal, or laryngeal sensorimotor competencies and the normal process of human communication including, but not limited to, disorders and related disorders of speech, articulation, fluency, voice, verbal and written language, auditory comprehension, cognition/communication, and the application of augmentative communication treatment and devices for treatment of such disorders

"Audiology" means the application of principles, methods, and procedures related to hearing and the disorders of hearing and to related language and speech disorders, whether of organic or nonorganic origin, peripheral or central, that impede the normal process of human communication including, but not limited to, disorders of auditory sensitivity, acuity, function, processing, or vestibular function, the application of aural habilitation, rehabilitation, and appropriate devices including fitting and dispensing of hearing instruments, and cerumen management to treat such disorders.
Speech-language pathology and Audiology services must be provided by a person licensed to provide these services in the State of Washington. These requirements are comparable to the qualifications specified in 42 CFR 440.110 (concerning physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders).

• The Provider One payment system enforces that Medicaid Benefits to which they are entitled are first accessed through the State Plan.
• This waiver service is only provided to individuals age 21 and over. All medically necessary Speech, Hearing and Language services for children under age 21 are covered in the State Plan pursuant to the EPSDT benefit.
• The dollar limitations for the waiver participant's IFS Waiver annual allocation limit the amount of this service she/he/they is authorized to receive as indicated in Appendix C-4.a.
• Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

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

☐ **Legally Responsible Person**
☒ **Relative**
☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Audiologist
Agency	Audiologist
Agency	Speech-Language Pathologist
Individual	Speech-Language Pathologist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Individual
Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

RCW 18.35.080 State law concerning certificates and licensure for speech-language pathologists and audiologists)

Certificate *(specify):*

WAC 246-828-095 (Department of Health administrative code concerning audiology minimum standards of practice)

Other Standard *(specify):*

RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.
Contract language regarding provider qualifications.

3. Qualifications

a. The Contractor shall be licensed, registered, and certified as is required by law for professionals whom
provide speech therapy services in the state of Washington.
b. Maintain a Core Provider Agreement with the Health Care Authority, which is the state Medicaid agency,
thus deeming you a Medicaid eligible provider.

Washington Administrative Code (WAC)

WAC 388-845-1010 Who is a qualified provider of extended state plan services?

Providers of extended state plan services must be certified, registered or licensed therapists as required by
law and contracted with DDA for the therapy they are providing.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Agency

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

RCW 18.35.080 State law concerning certificates and licensure for speech-language pathologists and audiologists)

Certificate *(specify):*

WAC 246-828-095 (Department of Health administrative code concerning audiology minimum standards of practice)

Other Standard *(specify):*

RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Qualifications

a. The Contractor shall be licensed, registered, and certified as is required by law for professionals whom
provide speech therapy services in the state of Washington.
b. Maintain a Core Provider Agreement with the Health Care Authority, which is the state Medicaid agency,
thus deeming you a Medicaid eligible provider.

Washington Administrative Code (WAC)

WAC 388-845-1010 Who is a qualified provider of extended state plan services?

Providers of extended state plan services must be certified, registered or licensed therapists as required by
law and contracted with DDA for the therapy they are providing.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Agency

Provider Type:

Speech-Language Pathologist

Provider Qualifications

License *(specify):*

RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists)

Certificate *(specify):*

WAC 246-828-105 (Department of Health administrative code concerning speech-language pathology--minimum standards of practice)

Other Standard *(specify):*

RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Qualifications

a. The Contractor shall be licensed, registered, and certified as is required by law for professionals whom
provide speech therapy services in the state of Washington.
b. Maintain a Core Provider Agreement with the Health Care Authority, which is the state Medicaid agency,
thus deeming you a Medicaid eligible provider.

Washington Administrative Code (WAC)

WAC 388-845-1010 Who is a qualified provider of extended state plan services?

Providers of extended state plan services must be certified, registered or licensed therapists as required by
law and contracted with DDA for the therapy they are providing.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Individual

Provider Type:

Speech-Language Pathologist

Provider Qualifications

License *(specify):*

RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists)

Certificate *(specify):*

WAC 246-828-105 (Department of Health administrative code concerning speech-language pathology--minimum standards of practice)

Other Standard *(specify):*

WAC 246-828-105 (Department of Health administrative code concerning speech-language pathology--minimum standards of practice)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Qualifications

a. The Contractor shall be licensed, registered, and certified as is required by law for professionals whom
provide speech therapy services in the state of Washington.
b. Maintain a Core Provider Agreement with the Health Care Authority, which is the state Medicaid agency,
thus deeming you a Medicaid eligible provider.

Washington Administrative Code (WAC)

WAC 388-845-1010 Who is a qualified provider of extended state plan services?

Providers of extended state plan services must be certified, registered or licensed therapists as required by
law and contracted with DDA for the therapy they are providing.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**

Items, equipment, or product systems, not related to a client's physical health, that are used to increase, maintain, or improve functional capabilities of waiver participants, increase safety, or increase social engagement in the community, as well as supports to directly assist the participant and caregivers to select, acquire, and use the technology.

Services are provided when outside the scope of Medicaid State Plan and EPSDT benefits.

Assistive technology includes:

(1) The evaluation of the needs of the waiver participant, including a functional evaluation in their customary environment;
(2) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices;
(3) Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing assistive technology devices;
(4) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
(5) Training or technical assistance for the participant and/or if appropriate, the child's or adult's family; and
(6) Training or technical assistance for professionals, including individuals providing education and rehabilitation services, employers, or other individuals who provide services to, employ, or are otherwise involved in the assistive technology related life functions of children or adults with disabilities.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.
Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.
State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way

interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.
The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.
Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

1) Assistive technology is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
2) Clinical and support needs for assistive technology are identified in the waiver participant's DDA person-centered assessment and documented in the person-centered service plan.
3) Assistive technology may be authorized as a waiver service only after Medicaid, EPSDT, and any other private health insurance plan benefits have been exhausted - by obtaining an initial denial of funding or information showing that the technology is not covered by Medicaid or private insurance.
4) The Department does not pay for technology determined by DSHS to be experimental.
5) The Department requires a written recommendation regarding her/his/their need for the technology. This recommendation must take into account that:
a)The professional has personal knowledge of and experience with the requested assistive technology; and
b)The professional has recently examined the waiver participant, reviewed her/his/their medical records when applicable, and conducted a functional evaluation.
6) The Department may require a written second opinion from a department selected professional.
7) Assistive technology requires prior approval by the DDA regional administrator or designee when $550 or more.
7) The dollar limitations for the waiver participant's IFS Waiver annual allocation limit the amount of assistive technology service she/he/they is authorized to receive as indicated in Appendix C-4.a.
8) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Physical Therapist
Agency	Audiologist
Agency	Speech-Language Pathologist
Agency	Rehabilitation Counselor
Individual	Behavior Specialist
Agency	AT Purchaser
Individual	Audiologist
Individual	Physical Therapist
Agency	Behavior Specialist
Individual	Recreation Therapist
Individual	Certified or Licensed Music Therapist
Individual	Rehabilitation Counselor
Agency	Recreation Therapist
Individual	AT Purchaser
Agency	Assistive Technology Vendor
Individual	Speech-Language Pathologist
Agency	Occupational Therapist
Agency	Certified or Licensed Music Therapist
Individual	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

RCW 18.74.040 (State law concerning examination for a physical therapy license)

RCW 18.74.040 (State law concerning licensure of physical therapists)

Chapter 2146-915 WAC (Department of Health administrative code concerning requirements for physical therapists)

Certificate *(specify):*

Other Standard *(specify):*

RCW 18.74.030 (State law concerning minimum qualifications to apply for licensure as a physical therapist)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

RCW 18.35.080 State law concerning certificates and licensure for speech-language pathologists and audiologists)

Certificate *(specify):*

WAC 246-828-095 (Department of Health administrative code concerning audiology minimum standards of practice)

Other Standard *(specify):*

RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must be certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Speech-Language Pathologist

Provider Qualifications

License *(specify):*

RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists)

Certificate *(specify):*

WAC 246-828-105 (Department of Health administrative code concerning speech-language pathology--minimum standards of practice)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Rehabilitation Counselor

Provider Qualifications

License *(specify):*

Counseling or related licensure through the Washington State Department of Health

Certificate *(specify):*

Certification through the Commission on Rehabilitation Counselor Certification

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Behavior Specialist

Provider Qualifications

License *(specify):*

State licensure and certification as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Chapter 246-924 WAC (Department of Health administrative code concerning requirements to become a licensed psychologist)

Chapter 18.71 RCW (Washington state law governing physician practice and licensure)

Chapter 18.71A RCW (Washington state law congerning physician assistant practice and licensure)

Certificate *(specify):*

Chapter 18.19 RCW (Washington state law concerning counselors, including certification)

Chapter 246-810 WAC (Department of Health administrative code concerning the practice of counseling)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

AT Purchaser

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. Qualified contracted providers will be:

1. Compensated for the time spent purchasing or issuing payment; and
2. Reimbursed for the actual amount spent on goods or services.

All purchasing tasks performed with or without the client present will be compensated at a standardized, statewide rate.
Providers must submit an invoice or the attached tracking form to case managers to justify the amount of reimbursement they are requesting.

Providers can only make purchases and bill their time for one client at a time and must not be reimbursed for mileage.

To be reimbursed for purchases and payments made on behalf of a client, a provider must use a financial business account (e.g., credits or checks).

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

RCW 18.35.080 State law concerning certificates and licensure for speech-language pathologists and audiologists)

Certificate *(specify):*

WAC 246-828-095 (Department of Health administrative code concerning audiology minimum standards of practice)

Other Standard *(specify):*

RCW 18.35.040 (State law concerning licensure and examination for speech-language pathologists and audiologists)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must be certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

RCW 18.74.040 (State law concerning examination for a physical therapy license)

RCW 18.74.040 (State law concerning licensure of physical therapists)

Chapter 2146-915 WAC (Department of Health administrative code concerning requirements for physical therapists)

Certificate *(specify):*

Other Standard *(specify):*

RCW 18.74.030 (State law concerning minimum qualifications to apply for licensure as a physical therapist)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Behavior Specialist

Provider Qualifications

License *(specify):*

State licensure and certification as required for the specific discipline:

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Chapter 246-924 WAC (Department of Health administrative code concerning requirements to become a licensed psychologist)

Chapter 18.71 RCW (Washington state law governing physician practice and licensure)

Chapter 18.71A RCW (Washington state law congerning physician assistant practice and licensure)

Certificate *(specify):*

Chapter 18.19 RCW (Washington state law concerning counselors, including certification)

Chapter 246-810 WAC (Department of Health administrative code concerning the practice of counseling)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Recreation Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

National certification through the National Council for Therapeutic Recreation Certification.
Washington State Registration

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Certified or Licensed Music Therapist

Provider Qualifications

License *(specify):*

1. Have, at minimum, a bachelor's degree;
2. Be a Board Certified Music Therapist (MT-BC) as defined by The Certification Board for Music Therapists; and
2. Have at least two years of experience working with individuals who experience developmental disabilities.
Effective January 1st, 2025 individuals contracting with DDA/DSHS to provide music therapy must be licensed under RCW Title 18 and have at least 1 year experience working with individuals who experience intellectual or developmental disabilities.

Certificate *(specify):*

Be a Board Certified Music Therapist (MT-BC) as defined by The Certification Board for Music Therapists

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must be certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Licensed music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Rehabilitation Counselor

Provider Qualifications

License *(specify):*

Counseling or related licensure through the Washington State Department of Health

Certificate *(specify):*

Certification through the Commission on Rehabilitation Counselor Certification

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Recreation Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

National certification through the National Council for Therapeutic Recreation Certification.
Washington State Registration

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must be certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

AT Purchaser

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. Qualified contracted providers will be:

1. Compensated for the time spent purchasing or issuing payment; and
2. Reimbursed for the actual amount spent on goods or services.

All purchasing tasks performed with or without the client present will be compensated at a standardized, statewide rate.
Providers must submit an invoice or the attached tracking form to case managers to justify the amount of reimbursement they are requesting.

Providers can only make purchases and bill their time for one client at a time and must not be reimbursed for mileage.

To be reimbursed for purchases and payments made on behalf of a client, a provider must use a financial business account (e.g., credits or checks).

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Assistive Technology Vendor

Provider Qualifications

License *(specify):*

Chbapter 19.02 RCS (State law concerning business licenses)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must be certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Stae Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Speech-Language Pathologist

Provider Qualifications

License *(specify):*

RCW 18.35.080 (State law concerning certificates and licensure for speech-language pathologists and audiologists)

Certificate *(specify):*

WAC 246-828-105 (Department of Health administrative code concerning speech-language pathology--minimum standards of practice)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

RCW 18.59.050 (State law concerning licensure requirements for occupational therapists)

Chapter 246-847 WAC (Department of Health administrative code concerning requirements for occupational therapists)

Certificate *(specify):*

Other Standard *(specify):*

RCW 18.598.060 (State law concerning examination requirements for occupational therapists)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Certified or Licensed Music Therapist

Provider Qualifications

License *(specify):*

1. Have, at minimum, a bachelor's degree;
2. Be a Board Certified Music Therapist (MT-BC) as defined by The Certification Board for Music Therapists; and
2. Have at least two years of experience working with individuals who experience developmental disabilities.
Effective January 1st, 2025 individuals contracting with DDA/DSHS to provide music therapy must be licensed under RCW Title 18 and have at least 1 year experience working with individuals who experience intellectual or developmental disabilities.

Certificate *(specify):*

Be a Board Certified Music Therapist (MT-BC) as defined by The Certification Board for Music Therapists

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Licensed music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

RCW 18.59.050 (State law concerning licensure requirements for occupational therapists)

Chapter 246-847 WAC (Department of Health administrative code concerning requirements for occupational therapists)

Certificate *(specify):*

Other Standard *(specify):*

RCW 18.598.060 (State law concerning examination requirements for occupational therapists)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized good and services as outlined in attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with DDA. Contractors located in the state of Washington must have a Universal business Identifier and Master Business License, as issued by the state Department of revenue. Out of state contractors must possess a Universal business Identifier and Master Business License only when it is required by Washington State law.
b. Providers of specialized services must b certified, registered, or licensed therapists as required by law and contracted with DDA for the therapy they are providing.

Washington Administrative Code (WAC)

WAC 388-845-0420 Who is a qualified provider of assistive technology?

The provider of assistive technology must be an assistive technology vendor contracted with DDA or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:
(1) Occupational therapist;
(2) Physical therapist;
(3) Speech and language pathologist;
(4) Certified music therapist;
(5) Certified recreation therapist;
(6) Audiologist; or
(7) Behavior specialist.

When providing the service through teleservice delivery , the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Engagement

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Community engagement services introduce and connect clients to community supports, resources and activities to help the waiver participant fully access their community for daily living needs or to reduce social isolation.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.

Assurances:

The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.

Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.

Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.

The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the

participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

Community engagement services are limited to the support needs identified in your DDA assessment and documented in your person-centered service plan. Community engagement services do not cover:
(a) Membership fees or dues; (b) Equipment related to activities; (c) The cost of any activities, and (d) The dollar limitations for the waiver participant's IFS waiver annual allocation limit the amount of community engagement services she/he/they is authorized to receive as indicated in Appendix C-4-a; and (e) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Engagement
Agency	Community Engagement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Engagement

Provider Category:

Individual

Provider Type:

Community Engagement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1) Experience with the community in which the participant lives and extensive knowledge of community organizations, informal clubs, community projects and events, local government resources, and businesses; and

2) Knowledge and skills necessary to
a) Find and engage leaders and members of these community resources to engage the waiver participant to become
an active member and build relationships based on common interests; and
b) Help the waiver participant develop skills that will increase her/his community integration.

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

Qualifications
g. The Contractor shall be licensed, registered, and certified as is required by law.
h. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW re.20A.710. If the Contractor has employees or
volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

388-845-0655 Who are qualified providers of community engagement services?

In order to be qualified, the provider of community engagement services must be one of the following individuals or organizations who have specialized training to provide services to people with developmental disabilities and are contracted with DDA to provide this service:
(1) Qualified providers must be a registered recreational therapist in the state of Washington or an individual provider contracted with DSHS or an
organization that provides services that promote skill development, improved functioning, increased independence as well as reducing or eliminating the
effects of illness or disability. Examples of organizations that provide community engagement services are:

(a) Community centers;

(b) Municipal parks and recreation programs;

(c) Therapeutic recreation camps and programs;

(d) Organizations providing community engagement services.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Engagement

Provider Category:

Agency

Provider Type:

Community Engagement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1) Experience with the community in which the participant lives and extensive knowledge of community organizations, informal clubs, community projects and events, local government resources, and businesses; and

2) Knowledge and skills necessary to
a) Find and engage leaders and members of these community resources to engage the waiver participant to become
an active member and build relationships based on common interests; and
b) Help the waiver participant develop skills that will increase her/his community integration.

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

Qualifications
g. The Contractor shall be licensed, registered, and certified as is required by law.
h. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW re.20A.710. If the Contractor has employees or
volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

388-845-0655 Who are qualified providers of community engagement services?

In order to be qualified, the provider of community engagement services must be one of the following individuals or organizations who have specialized training to provide services to people with developmental disabilities and are contracted with DDA to provide this service:
(1) Qualified providers must be a registered recreational therapist in the state of Washington or an individual provider contracted with DSHS or an
organization that provides services that promote skill development, improved functioning, increased independence as well as reducing or eliminating the
effects of illness or disability. Examples of organizations that provide community engagement services are:

(a) Community centers;

(b) Municipal parks and recreation programs;

(c) Therapeutic recreation camps and programs;

(d) Organizations providing community engagement services.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 Years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental adaptations provide physical adaptations to the existing home and existing rooms within the home required by the individual's person-centered service plan needed to allow an individual to physically access their home when those adaptations are not covered under the Medicaid state plan. The Environmental Adaptation must:

(a) Ensure the health, welfare and safety of the individual; or

(b) Enable the individual who would otherwise require institutionalization to function with greater independence in the home. Repairs to the home necessary due to property destruction caused by the participant; limited to the cost of restoration to original condition.

Environmental adaptations may include the installation of ramps and grab bars, widening of doorways, hardening of walls or windows, modification of bathroom facilities, or installing specialized electrical and/or plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual.

• DDA reserves the right to repair/replace with the most cost-effective/code compliant items that meet the client’s need(s).

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

The following service limitations apply to environmental adaptations:
• Prior approval by DDA is required.
• One bid is required for adaptations costing one thousand five hundred dollars or less.
• Two bids are required for adaptations costing more than one thousand five hundred dollars and equal to or less than five thousand dollars.
• Three bids are required for adaptations costing more than five thousand dollars.
• Environmental adaptations or improvements to the home are excluded if they are of general utility without direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, generators, etc.
• Environmental adaptations cannot add to the total square footage of the home.
• Environmental adaptations do not include fences.
• DDA may require an occupational therapist, physical therapist, or other qualified professional to recommend an appropriate environmental adaptation.
• Environmental adaptations must meet all local and state building codes.
• A deteriorated condition of the existing home, other construction work in process, or the location of the home in a flood plain, landslide zone or other hazardous site may limit or prevent adaptations approved by DDA.
• The dollar limitations for the waiver participant's IFS Waiver annual allocation limit the amount of Environmental Adaptation service she/he/they is authorized to receive as indicated in Appendix C-4.a.
• Environmental adaptations are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization or out of home placement.
• These services may not be furnished to individuals who receive residential habilitation services except when such services are furnished in the participant's own home.
• Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

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

☐ **Legally Responsible Person**
☒ **Relative**
☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Contractor
Agency	Registered Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Adaptations

Provider Category:
Individual
Provider Type:

Registered Contractor
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chapter 18.27 RCW (Washington state law concerning contractor registration)

Chapter 19.27 RCW (Washington state law concenring the state building code)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.
Contract language regarding provider qualifications.

2. Qualifications

The Contractor shall be currently registered as a general or specialty Contractor and in good standing with the Department of Labor and Industries under RCW 18.27, except as provided under TCW 18.27.090 Exemptions.

Washington Administrative Code (WAC)

WAC 388-845-0905 Who is a qualified provider for building these environmental adaptations?

The provider making these environmental adaptations must be a registered contractor per 18.27 RCW and contracted with DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., contractor registration) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Adaptations

Provider Category:

Agency

Provider Type:

Registered Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chapter 18.27 RCW (Washington state law concerning contractor registration)

Chapter 19.27 RCW (Washington state law concerning the state building code)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.
Contract language regarding provider qualifications.

2. Qualifications

The Contractor shall be currently registered as a general or specialty Contractor and in good standing with the Department of Labor and Industries under RCW 18.27, except as provided under TCW 18.27.090 Exemptions.

Washington Administrative Code (WAC)

WAC 388-845-0905 Who is a qualified provider for building these environmental adaptations?

The provider making these environmental adaptations must be a registered contractor per 18.27 RCW and contracted with DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., contractor registration) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Life Skills

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Individualized and community-based supports to assist a waiver participant to reach identified life skills goals to promote inclusion in their homes and communities as documented in their person-centered service plan. Life Skills offers teaching and training to a waiver participant to learn or maintain skills in:

- Self-empowerment (such as becoming more aware of strengths and weakness and therefore become better equipped to deal with problems)
- Safety awareness and self-advocacy (such as learning skills to for safety awareness or how to recognize and report abuse, neglect or exploitation)
- Interpersonal skills and effective communication (such as avoiding or mitigating inappropriate peer pressure)
- Coping strategies regarding typical life challenges (such as acclimating to a new family member or roommate)
- Managing daily tasks and acquiring adaptive skills (such as selecting appropriate outfits for various work and social occasions)

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.

Assurances:

The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.

Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.

Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
• The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.
• The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

• Life Skills is limited to the waiver participant's annual allocation in the IFS waiver.
• The need for this service is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan.
• Life Skills services are not included in the benefits available through special education, vocational, community first choice, behavioral health, skilled nursing, occupational therapy, physical therapy, or speech, language, and hearing services that are otherwise available through the Medicaid state plan, including early and periodic screening, diagnostics, and treatment, but are consistent with waiver objectives of avoiding institutionalization
• Life Skills services, not provided as a stabilization service, require prior approval by the DDA regional administrator or designee.
• Stabilization Services – Life Skills is a distinct and separate service from Life Skills, appears in PCSPs separately, is authorized separately, and has a unique and separate billing code.
• Since this service is one of the services covered under the aggregate service package, an expenditure limitation applies as indicated in Appendix C-4.a.
• Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Habilitation Provider
Individual	Certified Life Skills Coach
Agency	Certified Life Skills Coach
Individual	Specialized Habilitation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills

Provider Category:

Agency

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contract Standards
When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills

Provider Category:

Individual

Provider Type:

Certified Life Skills Coach

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The contractor must be a Life Skills Coach with current and valid certification. The State clarifies that this service provider must be a Life Skills Coach with current and valid certification and a minimum of one (1) year experience working with individuals who experience a developmental or intellectual disability.

Other Standard *(specify):*

The contractor must be a Life Skills Coach with current and valid certification.
Contract Standards
When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills

Provider Category:

Agency

Provider Type:

Certified Life Skills Coach

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The contractor must be a Life Skills Coach with current and valid certification. The State clarifies that this service provider must be a Life Skills Coach with current and valid certification and a minimum of one (1) year experience working with individuals who experience a developmental or intellectual disability.

Other Standard *(specify):*

The contractor must be a Life Skills Coach with current and valid certification.
Contract Standards
When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills

Provider Category:

Individual

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contract Standards
When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nurse Delegation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

(1) Services in compliance with WAC 246-840-910 through 246-840-970 (concerning delegation of nursing care tasks in community-based and in-home care settings) by a registered nurse to provide training and nursing management for

nursing assistants who perform delegated nursing tasks only when nurse delegation is not covered under the Medicaid state plan, including EPSDT.

(2) Delegated nursing tasks include, but are not limited to, administration of noninjectable medications except for insulin, blood glucose testing, and tube feedings.

(3) Services include the initial visit, care planning, competency testing of the nursing assistant, consent of the client, additional instruction and supervisory visits.

(4) Waiver participants who receive nurse delegation services must be considered "stable and predictable" by the delegated nurse.

As specified in Chapter 388-101 WAC (DSHS administrative code concerning certified community residential services and supports): Nurse Delegation means a registered nurse transfers the performance of selected nursing tasks to competent individuals in selected situations. (Within the scope of their license and pursuant to RCW 18.79.260 (Registered nurse Activities allowed Delegation of tasks), delegating nurses determine who is capable of providing a skilled nursing task and which task(s) the nurse determines can be safely delegated.) The registered nurse delegating the task retains the responsibility and accountability for the nursing care of the client. The registered nurse delegating the task supervises the performance of the unlicensed person;

(a) Nursing acts delegated by the registered nurse shall:

(i) Be within the area of responsibility of the registered nurse delegating the act;

(ii) Be such that, in the opinion of the registered nurse, it can be properly and safely performed by the person without jeopardizing the patient welfare;

(iii) Be acts that a reasonable and prudent registered nurse would find are within the scope of sound nursing judgment.

(b) Nursing acts delegated by the registered nurse shall not require the unlicensed person to exercise nursing judgment nor perform acts which must only be performed by a registered nurse, except in an emergency situation (RCW

18.79.240 (1)(b) and (2)(b))(Washington state law concerning provision of nursing assistance in the case of an emergency).

(c) When delegating a nursing act to an unlicensed person it is the registered nurse who shall:

(i) Make an assessment of the patient's nursing care need before delegating the task;

(ii) Instruct the unlicensed person in the delegated task or verify competency to perform or be assured that the person is competent to perform the nursing task as a result of the systems in place by the health care agency;

(iii) Recognize that some nursing interventions require nursing knowledge, judgment, and skill and therefore may not lawfully be delegated to unlicensed persons.

Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan. Waiver nurse delegation is designed to address nurse delegable tasks not covered by the State plan.

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

(1) Clinical and support needs for nurse delegation services are identified in the waiver participant's DDA person-centered assessment and documented in her/his/their person-centered service plan;
(2) The Department requires the delegating nurse's written recommendation regarding the waiver participant's need for the service. This recommendation must take into account that the nurse has recently examined the waiver participant, reviewed the waiver participant's medical records, and conducted a nursing assessment.
(3) The Department may require a written second opinion from a department-selected nurse delegator that meets the same criteria in subsection (2) of this section.
(4) The following tasks must not be delegated:
(a) Injections, other than insulin;
(b) Central lines;
(c) Sterile procedures; and
(d) Tasks that require nursing judgment.
(5) The dollar limitations for the waiver participant's annual allocation on the IFS Waiver limit the amount of nurse delegation service she/he/they may receive as indicated in Appendix C-4.a.
(6) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Registered Nurse
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Delegation

Provider Category:

Agency

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning practical and registered nursing, including licensure)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

2. Contractor Qualifications

a. Licensing Requirements. The Contractor shall:

Maintain all necessary licenses, registrations, and certifications as required by RCW 18.79.260, 18.88A.210 and WAC 246.840. Licenses, registrations and certifications must remain in good standing without any substantiated complains or sanctions during the period of performance of this Contract.

b. Minimum Qualifications. The Contractor shall:

(1) Possess a valid Washington State Registered Nurse license without any limitations or restrictions;

(2) Have one (1) year of experience as a Registered nurse;

(3) Have one (1) year of experience demonstrating skill and experience in client assessment, documentation of assessments and development of nursing care plans;

(4) Have demonstrated leadership, teaching experience, and the ability to work independently;

(5) Have demonstrated excellent oral and written communication skills; and

(6) Maintain current Professional Liability insurance coverage per Section 11 of this Contract.

The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1175 Who is a qualified provider of nurse delegation?

Providers of nurse delegation are registered nurses contracted with DDA to provide this service or employed by a nursing agency contracted with DDA to provide this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Delegation

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning practical and registered nursing, including licensure)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

2. Contractor Qualifications

a. Licensing Requirements. The Contractor shall:

Maintain all necessary licenses, registrations, and certifications as required by RCW 18.79.260, 18.88A.210 and WAC 246.840. Licenses, registrations and certifications must remain in good standing without any substantiated complains or sanctions during the period of performance of this Contract.

b. Minimum Qualifications. The Contractor shall:

(1) Possess a valid Washington State Registered Nurse license without any limitations or restrictions;

(2) Have one (1) year of experience as a Registered nurse;

(3) Have one (1) year of experience demonstrating skill and experience in client assessment, documentation of assessments and development of nursing care plans;

(4) Have demonstrated leadership, teaching experience, and the ability to work independently;

(5) Have demonstrated excellent oral and written communication skills; and

(6) Maintain current Professional Liability insurance coverage per Section 11 of this Contract.

The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-1175 Who is a qualified provider of nurse delegation?

Providers of nurse delegation are registered nurses contracted with DDA to provide this service or employed by a nursing agency contracted with DDA to provide this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Peer Mentoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Peer mentoring involves the provision of support and guidance to a waiver participant and family members of a waiver participant by a person with shared experience. Peer mentors may explain community services and programs and suggest strategies to the waiver participant and family to achieve the waiver participant's goals.

Peer mentoring actively engages participants and family members of participants to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver.

Peer mentoring does not provide case management services to a waiver participant; peer mentoring does not include determination of level of care, functional or financial eligibility for services or person-centered service planning. Peer mentoring does provide support to the participant and their family in locating and accessing other community services and programs that may assist the participant to engage in community life or provide supports to the participant.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.
Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.
State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.
The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

The services under the IFS waiver are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

(1) Support needs for peer mentoring are identified in the waiver participant's DDA person-centered assessment and documented in her/his/their person-centered service plan.
(2) Peer mentors cannot mentor their own family members.
(3) Peer mentoring does not provide case management services to a waiver participant; does not include determination of level of care, functional or financial eligibility for services or person-centered service planning.
(4) The dollar limitations for the waiver participant's annual allocation in the IFS Waiver limit the amount of peer mentoring service she/he/they is authorized to receive as indicated in Appendix C-4.a.
(5) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	**Organizations who provide peer support to individuals with developmental disabilities and their families.**
Individual	**Individuals who provide peer support to individuals with developmental disabilities and their families.**

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Mentoring

Provider Category:

Agency

Provider Type:

Organizations who provide peer support to individuals with developmental disabilities and their families.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Peer mentor certification as awarded by the organization to the individual providing the service. Organizations can include self-advocacy and parent organizations.

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications. State Operating Agency verified every 3 years. Organizations who provide peer support to individuals with developmental disabilities and their families. Peer mentor certification is awarded by the organization to the individual providing the service. Organizations can include self-advocacy and parent organizations. The peer mentor can be an individual with developmental disabilities or the member of a family that includes an individual with developmental disabilities.

Washington Administrative Code (WAC)

WAC 388-845-1191 Who are qualified providers of peer mentoring? Qualified providers include organizations who:
(1) Provide peer mentoring support and training to individuals with developmental disabilities or to families with a member with a developmental disability; and
(2) Are contracted with DDA to provide this service.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Mentoring

Provider Category:

Individual

Provider Type:

Individuals who provide peer support to individuals with developmental disabilities and their families.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications. State Operating Agency verified every 3 years. Organizations who provide peer support to individuals with developmental disabilities and their families. Peer mentor certification is awarded by the organization to the individual providing the service. Organizations can include self-advocacy and parent organizations. The peer mentor can be an individual with developmental disabilities or the member of a family that includes an individual with developmental disabilities.

Washington Administrative Code (WAC) 388-845-1191

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Person-Centered Plan Facilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Person-centered planning facilitation is an approach to forming life plans that is centered on the individual. It is used as a life planning model to enable individuals with disabilities or others requiring support to increase personal self-determination.

Person-centered planning facilitation includes:
1) Identifying and developing a potential circle of support.
2) Exploring what matters to the waiver participant by listening to and learning from the person.
3) Developing a vision for a meaningful life, as defined by the waiver participant.
4) Discovering capacities and assets of the waiver participant and her/his/their family, neighborhood, and support network.
5) Generating an action plan.
6) Facilitating follow-up meetings to track progress toward goals.

Person-Centered Planning Facilitation is a distinctly different service that does not duplicate nor replace the responsibilities of the DDA Case/Resource Manager who is responsible for developing the person-centered service plan, and this service does not replace an individual's person-centered service plan. The person-centered planning facilitators employ methods including total communications techniques, graphic facilitation of meetings and problem solving skills in the development of a person centered plan, such as PATH (Planning Alternative Tomorrows with Hope), MAPS (Making Action Plans), personal futures planning and person centered thinking tools.

Person-centered planning facilitators typically organize a circle of people who know and care about the individual and who assist the individual to organize individualized, natural and creative supports to achieve meaningful goals based on the individual's strengths and preferences. This team typically meets with the individual a number of times to build relationships, to explore strengths and interests and to build team unity. Then, in a major planning session that may last two to four hours or more, the team develops a comprehensive plan. The resultant plan may be in any format that is accessible to the individual, such as a document, a drawing or an oral plan recorded on tape or digital media.

By definition, person-centered planning facilitation is not a service oriented approach but a broad exploration of an individual's vision for a valued life that offers a platform for the individual and her/his trusted friends and family members to express this vision and commitments of support without limiting that expression to what can or will be provided by the service system.

In Washington State's experience, facilitated person-centered plans have been a source of significant support for individuals in transitional stages of their lives; for example, for young people transitioning from high school into employment and moving out of the family home.

Completed facilitated person-centered plans will inform, provide direction and offer details of a waiver participant's desires, goals and preferences to the DDA Case/Resource Manager who jointly develops with the wavier participant a written person-centered service plan based on the DDA assessment. The person-centered planning process is driven by the participant. The person-centered service plan reflects the services and supports that are important for the participant to meet the needs identified through the functional assessment as well as what is important to the individual with regard to preferences for the delivery of services and support.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes

for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.
Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.
State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.
The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.
Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

(1) Support needs for person-centered planning facilitation are identified in the waiver participant's DDA person-centered assessment and documented in her/his/their person-centered service plan.
(2) Person-centered planning facilitation may include follow up contacts with the waiver participant and her/his/their family to consult on plan implementation.
(3) The dollar limitations for the waiver participant's annual allocation in the IFS Waiver limit the amount of person-centered plan facilitation service she/he/they is authorized to receive as indicated in Appendix C-4.a.
(4) An employee of DDA cannot provider person-centered plan facilitation services.
(5) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Person-Centered Planning Facilitator

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Person-Centered Plan Facilitation

Provider Category:
Individual
Provider Type:

Person-Centered Planning Facilitator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Remote Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Remote Support is supervision, coaching, and consultation from a contracted Remote Support provider to a DDA waiver participant from a distant, HIPPA-compliant location that allows an HCBS waiver participant to increase their independence and safety in their home and community when not engaged in other HCBS services or informal supports that offer similar supports (personal care, etc.). Remote support allows an individual to live in their home without the intrusive presence of a caregiver when the individual's needs can be met without a caregiver being in-person. They are receiving their support in the setting they choose, by the providers they choose. This support not only allows the individual to be more independent and have increased autonomy, but directly supports community integration, rather than institutionalization, since the participant receives their needed supports in their chosen community and in a person-centered way.

Remote support will allow an individual more autonomy to move around their living space without the presence of someone right beside them, often doing things for them. Individuals will be given the opportunity to complete tasks on their own and have the ability to ask for help, if and when they need it. It allows the person the ability to ask for the presence of in-person support when they want it, as opposed to always having someone there.

Remote support allows an individual to go out into their community on their own if they wish, with the support of remote support devices. Clients are informed of the device capabilities and what the device can support them with in the community, and when they may need to call the remote support provider for assistance through the device. In another way, remote support allows for the participant to have the independence to live in their home, and to engage in other waiver services as intended with other providers or staff who are available to support them.

The state will finalize policy around remote support and informed consent. Clients and their representatives will acknowledge the risks of using technology in any setting. When remote support is added to a client's home where there is family living (and not providing informal support) the client can choose an area within the home to video call or video chat their remote support provider.

When an individual elects to receive remote support, the person-centered service plan will reflect how many hours/days per week an individual will receive this support. Policy will direct case managers to ensure that there is an identified backup plan for an individual who is receiving remote support and this information will be added to the client's person-centered service plan, and the evaluation plan the provider creates. Additionally, case managers are already required to check in with clients and their representatives every 6 months to review service delivery and follow-up on any issues or concerns raised.

The remote support vendor is responsible for following through with the client and other identified individuals identified on the client's person-centered service plan when a device fails or when the technology is not working. They are responsible for replacing the item and delivering it to the client in a timely manner. Individuals the client has identified in their person-centered service plan will be notified and the backup system will be put into motion so support is consistently in place. There is not an in-person component like other waiver services offering teleservice. The only component that would be in person is the initial installation of the devices and if the client chooses, the initial evaluation with the provider to determine what kind of devices would meet the client's need. This is usually done remotely, but some vendors may have the ability to conduct these in person, in which the state will leave that up to the client to decide.

Radio frequency identification (RFID) is a wireless system that uses tags and readers. Information is passed between a tag and the reader through radio waves at different frequencies. For use in remote support, this would look like out of bed detection/fall detection, monitoring the individual (through sensors) and equipment tracking.

Remote Support is intended to be a less-intrusive way of supporting an individual in their home. Live audio feed is referring to client or provider-initiated video calls. The client can initiate a video call anytime with their remote support provider, and the provider can initiate a video call if they have not heard from the client or monitoring data suggests there is a problem. Calls initiated by the provider must be answered by the client- the provider cannot just turn on the video call. If the client chooses to include video monitoring in their remote support plan, they can turn the camera on or off at any time.

Because this service is strengths-based and takes a very person-centered approach to what the client wants in their life, individual plans will look differently. The state requires identification of when the remote support provider will be expected to provide support to the client as well as what that is for (reminders for ADLs, medication reminders, check in, etc). The client can contact or initiate calls to their remote support provider at any time. In addition, the remote support provider is available 24/7 to the client but will only bill the state for approved schedule.

Remote support providers must be available to the client 24/7. Backup plans will be individualized and include identification of who will respond in-person to an individual when there is an emergency or simply if a client needs an in-person support for a specific task. DDA policy will direct case managers to ensure a solid backup plan is in place with documentation in the client's PCSP before authorizing services. Service may be received via teleservice as identified in the person-centered service plan. The waiver participant selects whether they want to receive service in person, via teleservice, or a combination of both. Providers engage with an individual through technology equipment with the capability for live two-way communication. Based on the person-centered plan and client choice,

there may be consistent monitoring through the use of non-video sensors that can capture movement and baseline movements of a client to ensure safety for the client in their home. If the client chooses to include video monitoring, there will be an exception to policy process to request that, and additional documentation will be required to move forward with such a request. Equipment used to meet this requirement shall include one or more of the following components:

1. Motion-sensing system
2. Radio frequency identification
3. Video calling via assistive technology
4. Live audio feed
5. Web-based monitoring systems

All necessary equipment to deliver Remote Supports is the responsibility of the Remote Supports provider and that the cost for this equipment is built into the rate for Remote Supports. Any technology equipment that must be purchased separately would be the property of the client and purchased through the Assistive Technology service. Need for service is based on the person-centered planning process and requested by the waiver participant.

Assurances:

The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.

Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.

Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

Continued at Main-B-Optional

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

1) Remote Support is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
2) Remote Supports must never be used to restrict a person from their home, community, or body autonomy.
3) Clinical and support needs for remote support are identified in the waiver participant's DDA person-centered assessment and documented in the person-centered service plan.
4) Remote Support cannot pay for internet, data plans, or Wi-Fi access separately. If internet is included as a component of the remote support technology, it may be included in the rate for the remote support service.
5) Guardians, legal representatives, parents, or family members cannot provide remote support to a waiver participant.
6) Remote Supports requires prior approval by the regional administrator or designee.
7) Up to the limit of the IFS annual allocation.
8) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Remote Supports

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:
Agency
Provider Type:

Remote Supports
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards
• Remote Support agencies must hold a Remote Support contract. At least 1 years' experience providing remote support to individuals with I/DD, medical fragility, or aging care needs, 2 years' experience using Assistive
technology with individuals with I/DD, medial fragility, or gaining care needs
• Remote support must be provided in a confirmed HIPPA compliant environment.
• When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service
provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Risk Assessment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Risk Assessments are professional evaluations of violent, stalking, sexually violent, predatory and/or opportunistic behavior to determine what person-centered, habilitative supports are necessary to successfully support the person to participate in their community. Risk Assessments funded by DDA are never used by courts for sentencing purposes and are never used in order to restrict a person from living in an integrated community setting.

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

1) Clinical and support needs for risk assessments are identified in the waiver participant's DDA person-centered assessment and documented in her/his/their person-centered service plan;
2) Prior approval is required by DDA for this service. This provides appropriate oversight of service utilization.
3) The costs of risk assessments do not count toward the dollar limits of the waiver participant's annual allocation in the IFS Waiver.
4) Limits are determined by the person-centered service planning process.
5) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Risk Assessor
Individual	Risk Assessor
Agency	Certified Sex Offender Treatment Provider (SOTP)
Individual	Certified Sex Offender Treatment Provider (SOTP)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Risk Assessment

Provider Category:

Individual

Provider Type:

Risk Assessor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. The State clarifies that this service provider must be a licensed psychologist, certified sexual offender treatment provider, or other provider identified in chapter 388-845 WAC and adhere to the standards in Title 18 RCW if applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Risk Assessment

Provider Category:

Individual

Provider Type:

Risk Assessor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. The State clarifies that this service provider must be a licensed psychologist, certified sexual offender treatment provider, or other provider identified in chapter 388-845 WAC and adhere to the standards in Title 18 RCW if applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Risk Assessment

Provider Category:

Agency

Provider Type:

Certified Sex Offender Treatment Provider (SOTP)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agency and Individual - Chapter 246-930 WAC (Department of Health administrative code concerning sex offender treatment provider requirements, including certification)
WAC 246-930-020 (Department of Health administrative code indicating only credentialed health care professionals may be certified as a sex offender treatment provider)
WAC 246-930-030 (Department of Health administrative code concerning the education required prior to examination to become a certified sex offender treatment provider)
WAC 246-930-040 (Department of Health administrative code concerning the professional experience required prior to examination to become a certified sex offender treatment provider)

Other Standard *(specify):*

Contract Standards
Individuals hired by an agency as an SOTP must meet the requirements of an individual SOTP.
Providers must have experience assessing sexually aggressive youth and/or adults.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Risk Assessment

Provider Category:

Individual

Provider Type:

Certified Sex Offender Treatment Provider (SOTP)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-930 WAC (Department of Health administrative code concerning sex offender treatment provider requirements, including certification)
WAC 246-930-020 (Department of Health administrative code indicating only credentialed health care professionals may be certified as a sex offender treatment provider)
WAC 246-930-030 (Department of Health administrative code concerning the education required prior to examination to become a certified sex offender treatment provider)
WAC 246-930-040 (Department of Health administrative code concerning the professional experience required prior to examination to become a certified sex offender treatment provider)

Other Standard *(specify):*

Contract Standards.
Individuals hired by an agency as an SOTP must meet the requirements of an individual SOTP.
Providers must have experience assessing sexually aggressive youth and/or adults.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Waiver skilled nursing provides chronic, long-term nursing services to address needs that are not met through the nursing services available in the Medicaid State Plan. Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan, including Early and Periodic Screening, Diagnosis and Treatment.
This waiver service is only provided to individuals age 21 and over with an exception for nurse delegation only when nurse delegation is not covered under the Medicaid state plan, including EPSDT.

• All medically necessary services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

• Skilled nursing is limited by: prior approval by DDA and skilled nursing hours are determined by DDA Nursing Care Consultant's skilled nursing assessment.

Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan.

Services include nurse delegation services provided by a registered nurse, including the initial visit, follow up instruction, and/or supervisory visits.

Services listed in the person-centered service plan must be within the scope of the State's Nurse Practice Act.

Safeguards that the State has in place to prevent duplicate billing for skilled nursing and nurse delegation include the following: 1) Skilled nursing requires a prior approval by DDA and 2) skilled nursing hours are determined by DDA Nursing Care Consultant’s skilled nursing assessment.

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

The following limitations apply to receipt of skilled nursing services:
• Skilled nursing services require prior approval by DDA.
• Skilled nursing hours must not exceed the number of hours determined by the DDA Nursing Care Consultant's skilled nursing assessment.

Nurse delegation is an intermittent service. The Registered Nurse Delegator is required to visit and provide supervision to the registered or certified nursing assistant (NAR/CNA) at least once every ninety (90) days. If providing diabetic training, the RND must visit the individual at least once a week for the first four (4) weeks. However, the RND may determine that some clients need to be seen more often.
Skilled nursing (not including nurse delegation) is only provided to individuals age 21 and over. All medically necessary skilled nursing for children under age 21 are covered in the State Plan pursuant to the EPSDT benefit.

The department reserves the right to require a second opinion by a department-selected provider.

Since this service is one of the services covered under the aggregate service package, an expenditure limitation applies as indicated in Appendix C-4.a.

The rate for skilled nursing services is based on fee schedule. All payments are made directly from the single state agency to the provider of service.

• Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

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

☐ **Legally Responsible Person**
☒ **Relative**
☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Practical Nurse (LPN)
Individual	Registered Nurse (RN)
Agency	Licensed Practical Nurse (LPN)
Agency	Registered Nurse (RN)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:

Licensed Practical Nurse (LPN)
Provider Qualifications
License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning practical and registered nursing)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3.Qualifications

c. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

d. Licensing Requirement. The Contractor must have and present an active license to practice as a registered nurse or as a licensed practical nurse, as defined under RCW 18.79, or an active in-home services agency license under 70.217. Agency staff providing Skilled Nursing Services must have an active license to practice as a registered nurse or as a licensed practical nurse, as defined under RCW 18.79.The Contractor shall maintain at all times current nursing licenses, registrations, and certificates as required by law.

e. By entering into this agreement, the Contractor certifies and provides assurances that the Contractor meets the minimum qualifications and that Contractor has the ability and willingness to carry out the responsibilities outlined in the Service Plan. The Contractor shall contact the Client's DDA case resource manager if at any time there are any concerns about the Contractor's ability to perform those responsibilities.

Washington Administrative Code (WAC)

WAC 388-845-1705 Who is a qualified provider of skilled nursing services?

The provider of skilled nursing services must be a licensed practical nurse (LPN) or registered nurse (RN) acting within the scope of the standards of nursing conduct or practice chapter 246-700 WAC and contracted with DDA to provide this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse (RN)

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning practical and registered nursing)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

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Washington Administrative Code (WAC)

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Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse (LPN)

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning practical and registered nursing)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3.Qualifications

c. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

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Washington Administrative Code (WAC)

WAC 388-845-1705 Who is a qualified provider of skilled nursing services?

The provider of skilled nursing services must be a licensed practical nurse (LPN) or registered nurse (RN) acting within the scope of the standards of nursing conduct or practice chapter 246-700 WAC and contracted with DDA to provide this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Registered Nurse (RN)

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning practical and registered nursing)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3.Qualifications

c. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

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e. By entering into this agreement, the Contractor certifies and provides assurances that the Contractor meets the minimum qualifications and that Contractor has the ability and willingness to carry out the responsibilities outlined in the Service Plan. The Contractor shall contact the Client's DDA case resource manager if at any time there are any concerns about the Contractor's ability to perform those responsibilities.

Washington Administrative Code (WAC)

WAC 388-845-1705 Who is a qualified provider of skilled nursing services?

The provider of skilled nursing services must be a licensed practical nurse (LPN) or registered nurse (RN) acting within the scope of the standards of nursing conduct or practice chapter 246-700 WAC and contracted with DDA to provide this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Clothing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Specialized clothing are nonrestrictive clothing adapted to the waiver participant's individual needs and related to her/his/their disability. Specialized clothing can include weighted clothing, clothing designed for tactile defensiveness or sensory integration, specialized footwear, or reinforced clothing. Services are provided when outside the scope of Medicaid State Plan and EPSDT benefits.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.

Assurances:

The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.

Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.

Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.

• The participant utilizing the services remote support and each person who shares a residence with that participant

will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

• The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

(1) Clinical and support needs for specialized clothing are identified in the waiver participant's DDA person-centered assessment and documented in her/his/their person-centered service plan.
(2) Specialized clothing may be authorized as a waiver service if the service is not covered by Medicaid or private insurance. The waiver participant must assist the Department in determining whether third party payments are available.
(3) The waiver participant must assist the Department in determining whether third party payments are available.
(4) Clothing of general use to all populations is not covered.
(5) The Department may require a second opinion from a department-selected health care provider.
(6) The department will require evidence that participants have accessed the full benefits of Medicaid, EPSDT, and private insurance before authorizing this waiver service.
(7) Initial denial of funding or other evidence that the service is not covered by another source will suffice.
(8) The dollar limitations for the waiver participant's annual allocation in the IFS Waiver limit the amount of specialized clothing service she/he/they may receive as indicated in Appendix C-4.a.
(9) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Clothing Shopper
Individual	Specialized Cothing Vendor
Agency	Specialized Clothing Vendor
Individual	Specialized Clothing Shopper

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Clothing

Provider Category:

Agency

Provider Type:

Specialized Clothing Shopper

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. The State clarifies that this service provider and its employees must hold a current Washington State Business License, maintain all additional and necessary licenses required by the State, and utilize a financial business account to make the approved purchases.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Clothing

Provider Category:

Individual

Provider Type:

Specialized Cothing Vendor

Provider Qualifications

License *(specify):*

Chapter 19.02 RCW (Washington state law concerning business licenses)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.
2. Qualifications
a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized goods and services as outlined in
Attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with
DDA. Contractors located in the state of Washington must have a Universal Business Identifier and Master Business License, as issued by the state
Department of Revenue. Out of state contractors must possess a Universal Business Identifier and Master Business License only when it is required by
Washington State law.

b. Providers of specialized services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they
are providing.

Washington Administrative Code (WAC)

WAC 388-845-1845 Who are qualified providers of specialized clothing?

Providers of specialized clothing are specialized clothing vendors contracted with DDA to provide this service.

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Clothing

Provider Category:

Agency

Provider Type:

Specialized Clothing Vendor

Provider Qualifications

License *(specify):*

Chapter 19.02 RCW (Washington state law concerning business licenses)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.
2. Qualifications
a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized goods and services as outlined in
Attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with
DDA. Contractors located in the state of Washington must have a Universal Business Identifier and Master Business License, as issued by the state
Department of Revenue. Out of state contractors must possess a Universal Business Identifier and Master Business License only when it is required by
Washington State law.

b. Providers of specialized services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they
are providing.

Washington Administrative Code (WAC)

WAC 388-845-1845 Who are qualified providers of specialized clothing?

Providers of specialized clothing are specialized clothing vendors contracted with DDA to provide this service.

When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Clothing

Provider Category:

Individual

Provider Type:

Specialized Clothing Shopper

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. The State clarifies that this service provider and its employees must hold a current Washington State Business License, maintain all additional and necessary licenses required by the State, and utilize a financial business account to make the approved purchases.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized equipment and supplies are durable or non- durable medical and non-medical equipment or supplies necessary to prevent institutionalization, not available under the Medicaid state plan, or in excess of what is available, that enables individuals to:
(a) Increase their abilities to perform their activities of daily living; or
(b) Perceive, control, or communicate with the environment in which they live; or
(c) Improve daily functioning through sensory integration.
This service also includes items necessary for life support; ancillary supplies and equipment necessary to the proper functioning of such items. Specialized equipment and supplies may include mobility devices, sensory regulation items, bathroom equipment, peri-care wipes, safety supplies, and other medical supplies not otherwise available on the Medicaid state plan, home health benefit or EPSDT.

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

(1) Specialized equipment and supplies are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
(2) Habilitative support needs for specialized equipment and supplies are identified in the waiver participant's DDA person-centered assessment and documented in her/his/their person-centered service plan.
(3) Specialized equipment and supplies require prior approval by the DDA Regional Administrator or designee when $550 or more.
(4) DDA reserves the right to require a second opinion by a department-selected provider.
(5) Items paid for with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid state plan or other private insurance or program or items not covered by the Medicaid state plan or other available insurance.
(6) Items must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability.
(7) Medications, prescribed or non-prescribed, and vitamins are excluded.
(8) Since this service is one of the services covered under the aggregate service package, an expenditure limitation applies as indicated in Appendix C-4.a.
(9) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Shopper
Agency	Specialized Equipment and Supplies Provider
Individual	Specialized Equipment and Supplies Provider
Agency	Shopper

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Individual

Provider Type:

Shopper

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. The State clarifies that this service provider and its employees must hold a current Washington State Business License, maintain all additional and necessary licenses required by the State, and utilize a financial business account to make the approved purchases.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Specialized Equipment and Supplies Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Individual

Provider Type:

Specialized Equipment and Supplies Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standard

Verification of Provider Qualifications

Entity Responsible for Verification:

State operating agency

Frequency of Verification:

every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Shopper

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. The State clarifies that this service provider and its employees must hold a current Washington State Business License, maintain all additional and necessary licenses required by the State, and utilize a financial business account to make the approved purchases.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individualized and community-based supports to assist a waiver participant to reach identified habilitative goals to promote inclusion in their homes and communities as documented in their person-centered service plan. Specialized Habilitation offers teaching and training to a waiver participant to learn or maintain skills in:

-Self-empowerment (such as becoming more aware of strengths and weakness and therefore become better equipped to deal with problems)

-Safety awareness and self-advocacy (such as learning skills to for safety awareness or how to recognize and report abuse, neglect or exploitation)

-Interpersonal skills and effective communication (such as avoiding or mitigating inappropriate peer pressure)

-Coping strategies regarding typical life challenges (such as acclimating to a new family member or roommate)

-Managing daily tasks and acquiring adaptive skills (such as selecting appropriate outfits for various work and social occasions)

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.

Assurances:

The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.

Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive. Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols

and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

The need for this service is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan.
Specialized habilitation services are not included in the benefits available through special education, vocational, community first choice, behavioral health, skilled nursing, occupational therapy, physical therapy, or speech, language, and hearing services that are otherwise available through the Medicaid state plan, including early and periodic screening, diagnostic, and treatment.
Specialized habilitation services, not provided as a stabilization service, require prior approval by the DDA regional administrator or designee.
Specialized Habilitation may not be authorized when habilitation supports are received through Residential Habilitation.
Since this service is one of the services covered under the client's IFS waiver annual allocation, an expenditure limitation applies as indicated in Appendix C-4.a.
Stabilization services – specialized habilitation is a distinct and separate services from specialized habilitation, appear in PCSPs separately, are authorized separately and have unique and separate billing codes.
Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Life Skills Coach

Provider Category	Provider Type Title
Individual	Specialized habilitation provider
Agency	Specialized habilitation provider
Agency	Cerfified Life Skills Coach

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Habilitation

Provider Category:

Individual

Provider Type:

Certified Life Skills Coach

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Contractor must be a Life Skills Coach with current and valid certification. The State clarifies that this service provider must be a Life Skills Coach with current and valid certification and a minimum of one (1) year experience working with individuals who experience a developmental or intellectual disability.

Other Standard *(specify):*

Contractor must be a Life Skills Coach with current and valid certification and meet Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Habilitation

Provider Category:

Individual

Provider Type:

Specialized habilitation provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Habilitation

Provider Category:

Agency

Provider Type:

Specialized habilitation provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Habilitation

Provider Category:

Agency

Provider Type:

Cerfified Life Skills Coach

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Contractor must be a Life Skills Coach with current and valid certification. The State clarifies that this service provider must be a Life Skills Coach with current and valid certification and a minimum of one (1) year experience working with individuals who experience a developmental or intellectual disability.

Other Standard *(specify):*

Contractor must be a Life Skills Coach with current and valid certification and meet Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Stabilization Services - Crisis Diversion Bed

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Crisis diversion beds are available to individuals determined by DDA to be at risk of institutionalization.

Crisis diversion beds may be provided in a client's home, licensed or certified setting.

Crisis diversion beds are short-term residential habilitation supports provided by trained specialists and include direct care, supervision or monitoring, habilitative supports, referrals, and consultation.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
Short-term is designed to reflect a temporary, multiple day or multiple week time frame.
Individualized person-centered planning identifies the minimally necessary time for a participant to be stabilized and returned to their own home, if an out of home setting is required, without a specific time limit. The need for this service is identified during the person-centered planning process and is documented in the waiver participant's person-centered service plan.
This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

It is anticipated some waiver clients will not be eligible for these services under the Medicaid State Plan, since an individual must have a mental health (MH) diagnosis to receive mental health State Plan services. A MH diagnosis is not a requirement for enrollment in waiver services.
DDA works closely with the Behavioral Health Administration (BHA) and the Health Care Authority to prevent duplication of BHO/State Plan MH Services. DSHS's expectation is that any DDA eligible client who meets the BHA, MCO or HCA access to care or medical necessity standards will receive behavioral health services through their health plans.

Community mental health services are provided through Behavioral Health Organizations, FFS Medicaid or Managed care Organizations, which carry out the contracting for local mental health care.
Individuals with primary diagnoses and functional impairments that are only a result of developmental or intellectual disability are not eligible for behavioral health waiver services. As a result, individuals with these support needs must display an additional covered diagnosis and a medically necessary support need in order to be served through the behavioral health system.

Individuals that do not meet access to care or medical necessity standards for the service type may be served under stabilization services.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.

Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.

The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

The duration and amount of this short term service needed to stabilize the individual in crisis is determined by DDA with consultation from a behavioral health professional.
Stabilization Services - Crisis Diversion Bed Services are limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.
"Short-term" reflects the fact that these services are not provided on an on-going basis. They are provided to individuals who are experiencing a crisis and are at risk of hospitalization. Once the crisis situation is resolved and the individual is stabilized, Stabilization services will be terminated.
The dollar limitations for the waiver participant's IFS Waiver annual allocation do not limit the amount of this service she/he/they is authorized to receive as indicated in Appendix C-4.a.

The State confirms that the crisis diversion bed service is never provided in an institutional setting. The State will specify that room and board is excluded from payment.

Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Crisis Diversion Bed Provider (licensed and contracted)
Agency	Crisis Diversion Bed Provider (State-Operated)
Agency	Crisis Diversion Bed Provider (Other department-licensed or certified agencies)
Agency	Crisis Diversion Bed Provider (Supported Living Agency)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Crisis Diversion Bed

Provider Category:

Agency

Provider Type:

Crisis Diversion Bed Provider (licensed and contracted)

Provider Qualifications

License *(specify):*

Provider will be licensed by Department of Children, Youth and Families as a staffed residential home under Chapter 110-145 WAC (Licensing Requirements for Group Care Facilities)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards and Chapter 388-833 WAC (Intensive Habilitation Services for Children)

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Children, Youth and Families

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Crisis Diversion Bed

Provider Category:

Agency

Provider Type:

Crisis Diversion Bed Provider (State-Operated)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 388-101 & 388-101D WAC (ALTSA & DDA administrative code concerning requirements for certified community residential services and support)

Other Standard *(specify):*

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Crisis Diversion Bed

Provider Category:

Agency

Provider Type:

Crisis Diversion Bed Provider (Other department-licensed or certified agencies)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 388-101 WAC (ALTSA administrative code concerning requirements for Certified Community residential services and support)

Other Standard *(specify):*

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every year

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Crisis Diversion Bed

Provider Category:

Agency

Provider Type:

Crisis Diversion Bed Provider (Supported Living Agency)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 388-101 WAC (ALTSA administrative code concerning requirements for certified Community residential services and support

Other Standard *(specify):*

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every year

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Stabilization Services - Life Skills

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Stabilization Services-Life Skills is short term individualized and community-based support when a client is experiencing crisis to assist the waiver participant to reach an identified life skills goal to promote inclusion in their homes and communities to avoid immediate institutionalization.
Stabilization Services-Life Skills offers teaching and training to a waiver participant to learn or maintain skills in:
• Self-empowerment (such as becoming more aware of strengths and weaknesses and therefore becoming better equipped to deal with problems).
• Safety awareness and self-advocacy (such as learning skills for safety awareness or how to recognize and report abuse, neglect or exploitation).
• Interpersonal skills and effective communication (such as avoiding or mitigating inappropriate peer pressure).
• Coping strategies regarding typical life challenges (such as acclimating to a new family member or roommate).
• Managing daily tasks and acquiring adaptive skills (such as selecting appropriate outfits for various work and social occasions).
Stabilization Services-Life Skills is short term individualized and community-based support when a client is experiencing crisis to assist the waiver participant to reach an identified life skills goal to promote inclusion in their homes and communities to avoid immediate institutionalization.
Stabilization Services-Life Skills offers teaching and training to a waiver participant to learn or maintain skills in:
• Self-empowerment (such as becoming more aware of strengths and weaknesses and therefore becoming better equipped to deal with problems)
• Safety awareness and self-advocacy (such as learning skills for safety awareness or how to recognize and report abuse, neglect or exploitation).
• Interpersonal skills and effective communication (such as avoiding or mitigating inappropriate peer pressure).
• Coping strategies regarding typical life challenges (such as acclimating to a new family member or roommate).
• Managing daily tasks and acquiring adaptive skills (such as selecting appropriate outfits for various work and social occasions).
• Stabilization Services – Life Skills is a distinct and separate service from Life Skills, appears in PCSPs separately, is authorized separately and has a unique and separate billing code.
Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.
Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and

successful service delivery.
State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.
The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.
Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
• The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.
• The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

• Stabilization services – Life Skills is intermittent and temporary.
• The need for this service is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan.
• Once the crisis situation is resolved and the individual is stabilized, stabilization services will be terminated.
• Any ongoing need for Life Skills services will be met under the stand-alone Life Skills services category for eligible clients.
• The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
• Stabilization Services – Life Skills is a distinct and separate service from Life Skills, appears in PCSPs separately, is authorized separately and has a unique and separate billing code.
• Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Specialized Habilitation Provider
Agency	Specialized Habilitation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Life Skills

Provider Category:

Individual

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contract Standards
When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Life Skills

Provider Category:

Agency

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contract Standards
When providing telehealth, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Stabilization Services - Specialized Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Stabilization Services-Specialized Habilitation is short term individualized and community-based support when a client is experiencing crisis to assist the waiver participant to reach an identified habilitative goal to promote inclusion in their homes and communities to avoid immediate institutionalization.
Specialized Habilitation offers teaching and training to a waiver participant to learn or maintain skills in:
• Self-empowerment (such as becoming more aware of strengths and weaknesses and therefore becoming better equipped to deal with problems).
• Safety awareness and self-advocacy (such as learning skills for safety awareness or how to recognize and report abuse, neglect or exploitation).
• Interpersonal skills and effective communication (such as avoiding or mitigating inappropriate peer pressure).
• Coping strategies regarding typical life challenges (such as acclimating to a new family member or roommate).
• Managing daily tasks and acquiring adaptive skills (such as selecting appropriate outfits for various work and social occasions).

Stabilization Services-Specialized Habilitation is short term individualized and community-based support when a client is experiencing crisis to assist the waiver participant to reach an identified habilitative goal to promote inclusion in their homes and communities to avoid immediate institutionalization.

Specialized Habilitation offers teaching and training to a waiver participant to learn or maintain skills in:
• Self-empowerment (such as becoming more aware of strengths and weaknesses and therefore becoming better equipped to deal with problems)
• Safety awareness and self-advocacy (such as learning skills for safety awareness or how to recognize and report abuse, neglect or exploitation).
• Interpersonal skills and effective communication (such as avoiding or mitigating inappropriate peer pressure).
• Coping strategies regarding typical life challenges (such as acclimating to a new family member or roommate).
• Managing daily tasks and acquiring adaptive skills (such as selecting appropriate outfits for various work and social occasions).
• Stabilization Services – Specialized Habilitation is a distinct and separate service from Specialized Habilitation, appears in PCSPs separately, is authorized separately and has a unique and separate billing code.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive. Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource

Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.
State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.
The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.
Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

Stabilization services – Specialized Habilitation is intermittent and temporary.
The need for this service is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan.
Once the crisis situation is resolved and the individual is stabilized, stabilization services will be terminated. Any ongoing need for Specialized Habilitation services will be met under the stand-alone Specialized Habilitation services category for eligible clients. Individuals receiving Residential Habilitation will receive ongoing habilitation support from their residential habilitation services provider.
The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
Stabilization Services – Specialized Habilitation is a distinct and separate service from Specialized Habilitation, appears in PCSPs separately, is authorized separately and has a unique and separate billing code.
The dollar limitations for the waiver participant's IFS Waiver annual allocation do not limit the amount of this service she/he/they is authorized to receive as indicated in Appendix C-4.a.

Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized habilitation provider
Individual	Specialized habilitation provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Specialized Habilitation

Provider Category:
Agency
Provider Type:

Specialized habilitation provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Specialized Habilitation

Provider Category:

Individual

Provider Type:

Specialized habilitation provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Stabilization Services - Staff/Family Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Stabilization Services – Staff/Family Consultation is a therapeutic service that assist family members, unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and that are not covered by the Medicaid state plan, and are necessary to improve the individual's independence and inclusion in their community. This service is not intended to instruct paid staff on the competencies relative to their field they are required to have or to provide training required to meet provider qualifications, but rather to support staff in meeting the individualized and specific needs of the waiver participant. The person-centered service plan, developed by the case/resource manager in collaboration with the waiver participant and the waiver participant's family, provides the high-level summary of services and goals for each specified waiver service. The plan developed by the consultant provides step-by-step details necessary to reach a goal by implementing a specific course of supports by the participant's family or paid providers.

Consultation, such as assessment, the development, training and technical assistance to a home or community support plan, and monitoring of the provider and individual in the implementation of the plan, is provided to families or direct staff to meet the specific needs of the waiver participant as outlined in the individual's person-centered service plan, including:
(a) Health and medication monitoring to report to health care provider;
(b) Positioning and transfer;
(c) Basic and advanced instructional techniques;
(d) Augmentative communication systems;
(e) Consultation with potential referral resources (mental health crisis line or end-harm line);
(f) Diet and nutritional guidance;
(g) Disability information and education;
(i) Strategies for effectively and therapeutically interacting with the participant;
(h) Environmental consultation;
(j) Assistive Technology;
(k) Individual and family counseling; and
(k) Parenting skills.

Stabilization Services – Staff/Family Consultation Services are therapeutic services that assist family members, unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and that are not covered by the Medicaid state plan and are necessary to improve the individual's independence and inclusion in their community. This service is not intended to instruct paid staff on the competencies relative to their field they are required to have or to provide training required to meet provider qualifications, but rather to support staff in meeting the individualized and specific needs of the waiver participant. The person-centered service plan, developed by the case/resource manager in collaboration with the waiver participant and the waiver participant's family, provides the high-level summary of services and goals for each specified waiver service.

The plan developed by the consultant provides step-by-step details necessary to reach a goal by implementing a specific course of supports by the participant's family or paid providers.

Consultation, such as assessment, the development, training and technical assistance to a home or community support plan, and monitoring of the provider and individual in the implementation of the plan, is provided to families or direct staff to meet the specific needs of the waiver participant as outlined in the individual's person-centered service plan, including:
(a) Health and medication monitoring to report to health care provider;
(b) Positioning and transfer;
(c) Basic and advanced instructional techniques;

(e) Augmentative communication systems;
(f) Consultation with potential referral resources (mental health crisis line or end-harm line);
(g) Diet and nutritional guidance;
(h) Disability information and education;
(i) Strategies for effectively and therapeutically interacting with the participant;
(j) Environmental consultation;
(k) Assistive Technology;
(l) Individual and family counseling; and
(m) Parenting skills.

Stabilization Services – Staff/Family Consultation is a distinct and separate service from Staff/Family Consultation, appears in PCSPs separately, is authorized separately and has a unique and separate billing code.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.

Assurances:

The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.

Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.

Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.

The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the

participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

Stabilization services – Staff/Family Consultation is intermittent and temporary.
The need for this service is identified during the person-centered planning process and documented in the waiver participant's person-centered service plan with consultation by a behavioral health specialist when appropriate.
Service is provided to the waiver participant who is experiencing a crisis and is at risk of hospitalization. Once the crisis situation is resolved and the individual is stabilized, stabilization services will be terminated. Any ongoing need for Staff/Family Consultation will be met under the stand-alone Staff/Family Consultation category.
The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
Stabilization Services – Staff/Family Consultation is distinct and separate services from Staff/Family Consultation, appears in PCSPs separately, is authorized separately and has a unique and separate billing code.
The dollar limitations for the waiver participant's IFS Waiver annual allocation do not limit the amount of this service she/he/they is authorized to receive as indicated in Appendix C-4.a.

Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Staff/Family Consultation Services
Agency	Staff/Family Consultation Services
Agency	Specialized Habilitation Provider
Individual	Specialized Habilitation Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Stabilization Services - Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Staff/Family Consultation Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Staff/Family Consultation providers shall be licensed, registered or certified in Washington State according to the standards of their profession as listed below:
1) Audiologist licensed in accordance with RCW 18.35;
2) Licensed practical nurse licensed in accordance with RCW 18.79;
3) Marriage and family therapist licensed in accordance with RCW 18.225;
4) Mental health counselor licensed in accordance with RCW 18.225;
5) Occupational therapist licensed in accordance with RCW 18.59;
6) Physical therapist licensed in accordance with RCW 18.74;
7) Registered nurse licensed in accordance with RCW 18.79;
8) Sex offender treatment provider licensed in accordance with RCW 18.155;
9) Speech/language pathologist licensed in accordance with RCW 18.35;
10) Social worker licensed in accordance with RCW 18.225;
11) Psychologist licensed in accordance with RCW 18.225;
12) Certified American Sign Language instructor;
13) Nutritionist licensed in accordance with RCW 18.138;
14) Counselors certified in accordance with RCW 18.19;
15) Certified dietician licensed in accordance with RCW 18.138;
16) Professional advocacy organization;
17) Recreation therapist registered certified in Washington in accordance with RCW 18.230 and certified by the national council for therapeutic recreation;
18) Educator or teacher certified in accordance with RCW 181.79A;
19) Providers listed in WAC 388-845-0506 and with a current contract with DDA to provide CIIBS intensive services; or
20) Or other provider identified in WAC chapter 388-845 for Staff/Family Consultation.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Staff/Family Consultation Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Staff/Family Consultation providers shall be licensed, registered or certified in Washington State according to the standards of their profession as listed below:
1) Audiologist licensed in accordance with RCW 18.35;
2) Licensed practical nurse licensed in accordance with RCW 18.79;
3) Marriage and family therapist licensed in accordance with RCW 18.225;
4) Mental health counselor licensed in accordance with RCW 18.225;
5) Occupational therapist licensed in accordance with RCW 18.59;
6) Physical therapist licensed in accordance with RCW 18.74;
7) Registered nurse licensed in accordance with RCW 18.79;
8) Sex offender treatment provider licensed in accordance with RCW 18.155;
9) Speech/language pathologist licensed in accordance with RCW 18.35;
10) Social worker licensed in accordance with RCW 18.225;
11) Psychologist licensed in accordance with RCW 18.225;
12) Certified American Sign Language instructor;
13) Nutritionist licensed in accordance with RCW 18.138;
14) Counselors certified in accordance with RCW 18.19;
15) Certified dietician licensed in accordance with RCW 18.138;
16) Professional advocacy organization;
17) Recreation therapist registered certified in Washington in accordance with RCW 18.230 and certified by the national council for therapeutic recreation;
18) Educator or teacher certified in accordance with RCW 181.79A;
19) Providers listed in WAC 388-845-0506 and with a current contract with DDA to provide CIIBS intensive services; or
20) Or other provider identified in WAC chapter 388-845 for Staff/Family Consultation.

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contracts Standard

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Stabilization Services - Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

a. The contractor must be a Life Skills Coach with current and valid certification, or have a Bachelor's, Master's, or Doctoral degree in the field of psychology, sociology, social work, education, child development, gerontology, recreation therapy, nursing, or other related field approved in advance by DDA, or be in a University internship program for psychology, sociology, social work, education, child development, gerontology, recreation therapy, or nursing and be supervised by the University's internship program.
b. The Contractor must have a minimum of one year experience working with individuals who experience a developmental or intellectual disability.
Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Staff/Family Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

• Clinical and therapeutic services that assist formal (paid) and informal (unpaid) caregivers, support staff, or family members in carrying out individual treatment/support plans.
• Professional services are those, and that are not covered by the Medicaid state plan, and are necessary to improve the individual's independence and inclusion in their community.
• This service is not intended to instruct paid staff/family on the competencies relative to their field they are required to have or to provide training required to meet provider qualifications, but rather to support staff/family in meeting the individualized and specific needs of the waiver participant.
• The person-centered service plan, developed by the case/resource manager in collaboration with the waiver participant and the waiver participant's staff/family, provides the high-level summary of services and goals for each specified waiver service.
• The plan developed by the consultant provides step-by-step details necessary to reach a goal by implementing a specific course of supports by the participant's family or paid providers.

• Consultation, such as assessment, the development, training and technical assistance to a home or community support plan, and monitoring of the provider and individual in the implementation of the plan, is provided to families or direct staff to meet the specific needs of the waiver participant as outlined in the waiver participant's person-centered service plan, including:
(a) Health and medication monitoring to report to the healthcare provider;
(b) Positioning and transfer;
(c) Basic and advanced instructional techniques;
(d) Augmentative communication systems;
(e) Consultation with potential referral resources (mental health crisis line or end-harm line);
(f) Diet and nutritional guidance;
(g) Disability information and education;
(h) Strategies for effectively and therapeutically interacting with the participant;
(i) Environmental consultation;
(j) Individual and family counseling;
(k) Assistive technology; and
(l) Parenting skills.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.
Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on

assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.

State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.

Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.

The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.

The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant’s video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant’s Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client’s file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

(1) Clinical and support needs for staff/family consultation are identified in the waiver participant's DDA person-centered assessment and documented in her/his/their person-centered service plan.
(2) Expenses to the family or provider for room and board or attendance, including registration, at conferences are excluded as a service under staff/family consultation.
(3) Services will not duplicate services available through third party payers or social service organizations or schools.
(4) The dollar limitations in the waiver participant's annual allocation in the IFS Waiver limit the amount of staff/family consultation she/he/they is authorized to receive as indicated in Appendix C-4.a.
(5) Individual and Family Counseling is available when the waiver participant has documentation in the person-centered service plan that they engage in assaults toward family members and are receiving behavior support to address
those assaultive behaviors.
(6) Stabilization services – staff/family consultation is a distinct and separate services from staff/family consultation, appear in PCSPs separately, are authorized separately and has a unique and separate billing code.
(7) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from
Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Mental Health Counselor
Individual	Social Worker
Agency	Recreation Therapist registered in WA and certified by the National Council for Therapeutic Recreation
Agency	Specialized Habilitation Provider
Individual	Registered Nurse (RN) or Licensed Practical Nurse (LPN)
Individual	Teacher
Agency	Sex Offender Treatment Provider (SOTP)
Agency	Counselors registered or certified in accordance with the requirements of Chapter 18.19 RCW.
Individual	Certified American Sign Language Instructor
Agency	Physical Therapist
Individual	Psychologist
Individual	Mental Health Counselor
Agency	Occupational Therapist
Individual	Recreation Therapist registered in WA and certified by the National Council for Therapeutic Recreation
Agency	Marriage and Family Therapist
Individual	Speech/Language Pathologist
Individual	Counselors registered or certified in accordance with the requirements of Chapter 18.19 RCW.
Agency	Audiologist
Individual	Certified Life Skills Coach
Agency	Registered Nurse (RN) or Licensed Practical Nurse (LPN)
Agency	Certified American Sign Language Instructor

Provider Category	Provider Type Title
Individual	Psychiatrist
Agency	Psychologist
Individual	Certified Professional Organizer
Individual	Nutritionist
Agency	Certified Dietician
Individual	Providers listed in WAC 388-845-0506 (providers of Behavior Support and Consultation under the CIIBS Waiver) and contracted with DDA to provide CIIBS Intensive services.
Individual	Marriage and Family Therapist
Individual	Audiologist
Agency	Certified Life Skills Coach
Agency	Psychiatrist
Agency	Social Worker
Individual	Specialized Habilitation Provider
Individual	Certified Dietician
Agency	Certified Professional Organizer
Agency	Providers listed in WAC 388-845-0506 (providers of Behavior Support and Consultation under the CIIBS Waiver) and contracted with DDA to provide CIIBS Intensive services.
Individual	Sex Offender Treatment Provider (SOTP)
Agency	Professional Advocacy Organization
Agency	Speech/Language Pathologist
Individual	Physical Therapist
Individual	Occupational Therapist
Agency	Nutritionist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Recreation Therapist registered in WA and certified by the National Council for Therapeutic Recreation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

National certification through the National Council for Therapeutic Recreation Certification.
Washington State Registration

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Registered Nurse (RN) or Licensed Practical Nurse (LPN)

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning requirements for Practical and Registered Nursing)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Teacher

Provider Qualifications

License *(specify):*

Certificate *(specify):*

WAC 181-79A

Other Standard *(specify):*

Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Sex Offender Treatment Provider (SOTP)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-930 WAC (Department of Health administrative code concerning requirements for Sex Offender Treatment Providers)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Counselors registered or certified in accordance with the requirements of Chapter 18.19 RCW.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-810 WAC (Department of Health administrative code concerning requirements for counselors)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Certified American Sign Language Instructor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification as an American Sign Language (ASL) Instructor

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Chapter 246-915 WAC (Department of Health administrative code concerning requirements for physical therapists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Chapter 246-924 WAC (Department of Health administrative code concerning requirements for psychologists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Chapter 246-847 WAC (Department of Health administrative code concerning requirements for Occupational Therapists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Recreation Therapist registered in WA and certified by the National Council for Therapeutic Recreation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

National certification through the National Council for Therapeutic Recreation Certification.
Washington State Registration

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Speech/Language Pathologist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-828-105 (Department of Health administrative code concerning speech-language pathology-minimum standards of practice)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Counselors registered or certified in accordance with the requirements of Chapter 18.19 RCW.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-810 WAC (Department of Health administrative code concerning requirements for counselors)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

WAC 246-828-095 (Department of Health administrative code concerning audiology minimum standards of practice)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Certified Life Skills Coach

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Registered Nurse (RN) or Licensed Practical Nurse (LPN)

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning requirements for Practical and Registered Nursing)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Chapter 246-840 WAC (Department of Health administrative code concerning requirements for Practical and Registered Nursing)

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Certified American Sign Language Instructor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification as an American Sign Language (ASL) Instructor

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Chapter 18.71 RCW (State law concerning requiremetns for Physicians)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Chapter 246-924 WAC (Department of Health administrative code concerning requirements for psychologists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Certified Professional Organizer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified as a professional organizer.

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Nutritionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 18.138 RCW (Washington state law concerning dietitians and nutritionists, including certification)

Chapter 246-822 WAC (Department of Health administrative code concerning certified dietitians and nutritionists)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Certified Dietician

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 18.138 RCW (State law concerning requirements for Dietitians and Nutritionists)

Chapter 246-822 WAC (DOH administrative code concerning requirements for Dietitians or Nutritionists)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Providers listed in WAC 388-845-0506 (providers of Behavior Support and Consultation under the CIIBS Waiver) and contracted with DDA to provide CIIBS Intensive services.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Certified music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

WAC 246-828-095 (Department of Health administrative code concerning audiology minimum standards of practice)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Certified Life Skills Coach

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Chapter 18.71 RCW (State law concerning requiremetns for Physicians)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Specialized Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Certified Dietician

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 18.138 RCW (State law concerning requirements for Dietitians and Nutritionists)

Chapter 246-822 WAC (DOH administrative code concerning requirements for Dietitians or Nutritionists)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Certified Professional Organizer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified as a professional organizer.

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Providers listed in WAC 388-845-0506 (providers of Behavior Support and Consultation under the CIIBS Waiver) and contracted with DDA to provide CIIBS Intensive services.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Sex Offender Treatment Provider (SOTP)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-930 WAC (Department of Health administrative code concerning requirements for Sex Offender Treatment Providers)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Professional Advocacy Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Speech/Language Pathologist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-828-105 (Department of Health administrative code concerning speech-language pathology-minimum standards of practice)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Chapter 246-915 WAC (Department of Health administrative code concerning requirements for physical therapists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Chapter 246-847 WAC (Department of Health administrative code concerning requirements for Occupational Therapists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Staff/Family Consultation

Provider Category:

Agency

Provider Type:

Nutritionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 18.138 RCW (Washington state law concerning dietitians and nutritionists, including certification)

Chapter 246-822 WAC (Department of Health administrative code concerning certified dietitians and nutritionists)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.

3. Contractor Qualifications

a. In accordance with WAC 388-845-2005, to provide staff/family consultation and training, a provider must be listed as a qualified professional, see WAC 388-845-2005, be licensed, registered or certified and contracted with DDA. Recreation therapist must be certified by the National Council for Therapeutic Recreation.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to Clients in the course of performing the work under this Contract, the Contractor will conduct criminal history background checks on those employees.

Washington Administrative Code (WAC)

Proposed WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training?

To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Licensed music therapist (for CIIBS only);
(19) Psychiatrist; or
(20) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Parenting

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported parenting services are professional services offered to parents and prospective parents with developmental disabilities who are enrolled on the IFS Waiver.

Prospective parents are waiver participants who are pregnant or who are in the process of adopting a child.

Supported parenting offers professional services to the parent who is a waiver participant in preparation for the role of being a parent.

Services may include teaching, parent coaching and other supportive strategies in areas critical to parenting, including child development, nutrition and health, safety, childcare, money management, time and household management and housing.

Supported parenting services are designed to build parental skills around the child's developmental domains of cognition, language, motor, social-emotional and self-help.

In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to knowledge of and skills in child development and family dynamics.

Teleservice is an available service delivery option if chosen by the participant or their guardian (if appropriate), appropriately meets the participant's assessed needs as documented in their person-centered service plan and is provided within the scope of the service being delivered. This service may be received in person or via teleservice as identified in the PCSP. The waiver participant selects whether they want to receive the service in person, via teleservice, or a combination of both. Teleservice is a remote service delivery method where the service is delivered by the provider to the participant via phone, video, computer, or other technology and that the technology and data storage is HIPAA compliant.
Assurances:
The well-developed person-centered service plan will document the participant's specific health and welfare needs and how each service selected by the participant contributes to meeting the participant's needs and does not duplicate supports. The PCSP is the first resource that will ensure the health and safety of that participant. The PCSP identifies supervision and physical assistance support needs that inform the decision making of whether teleservice is appropriate for the client. The service authorization system (ProviderOne) has distinct and separate service codes for each waiver service and has built-in system logic that prevents duplication of services. DDA policies and procedures provide guidance to Case Resource Managers on developing effective person-centered service plans that identify services and service delivery methods that best meet their unique health and welfare needs without any duplication of services.
Teleservice will be the service delivery method for a particular service at the direction of the participant, not by the preference of the service provider. A teleservice agreement form will be required prior to authorization of teleservice delivery. This form will document the client's desired level of in person to teleservice delivery and will remind clients that they can change their mind about frequency of teleservice delivery at any time. This agreement is intended to assist in clear and documented communication between the client, DDA, and the provider (in addition to the person-centered service plan) to ensure the client is the driver of the method of service delivery they receive.
Case/Resource Managers will consult with their participants and family members, if appropriate, to develop the PCSP that includes the specific services and service delivery methods that best meets the participant's unique health and welfare needs. Participants will document in their PCSPs what approximate percentage of service delivery they desire to receive via teleservice. The State is not mandating what percentage of time teleservice can be utilized, to ensure person-centered service planning and promote client choice. Participants who need hands on assistance/physical assistance will require careful person-centered planning coordinated by their Case/Resource Manager to determine if teleservice delivery is a practical or feasible option for the successful delivery of services. Voice-activated communication devices may be an option that some participants select to ensure that remote service delivery will work for them. Other clients may require in person service delivery only to ensure safety and successful service delivery.
State will permit recording of live interactions with the participant via audio or video technology only at the request of the participant. Policy will include specific language around bathrooms and bedrooms. Video cameras are not permissible in bathrooms. If a client requests a video camera in their bedroom, there must be an approved exception to policy in place and the device must be situated in a way that does not compromise client privacy. Live 2-way interactions are always initiated by the participant. The participant can initiate the service when needed and turn off the equipment when not needed.

The State believes teleservice will be an important component in a well-developed and balanced PCSP that focuses on the specific wants and health and welfare needs of the participant. Experience during the COVID-19 pandemic has shown that teleservice can facilitate community integration in a person-centered way. Washingtonians in the broader community utilize both technology-supported remote and in-person community service environments, and the proposed change in waiver services give waiver clients the same opportunity to participate in their community as everyone else.
Providers employing teleservice delivery will be guided by Policy and will continue to follow all service protocols and report any concerns they have to the Case/Resource Manager and make any appropriate incident reports.
The provider delivering services remotely will be responsible for using an approved delivery platform that the client is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.). If a client is unable to use technology for teleservice delivery, then in person service delivery would be the appropriate service delivery mechanism for the client and this would be discussed during the person-centered planning meeting.
The participant utilizing the services remote support and each person who shares a residence with that participant will be fully informed of what remote service delivery entails including, but not limited to: (A) that remote staff may observe their activities if they are within the view of the participant's video communication device; (B) that the participant decides where in the residence the remote support will occur; (C) whether or not recordings of sessions will be made (the participant's Case/Resource Manager will document in the PCSP); (D) that the participant will control the operation of the communication device, when it is turned on and when it is turned off. Please note that this service is not approved for clients receiving residential habilitation services.

The state will use the CARE assessment to determine client need for technology and remote support through the person-centered planning process. If a client requests that a video camera be placed in their home to use in the provision of remote support, there must be an exception to policy (ETP) in place with justification as to why the camera is needed instead of a simple sensor. The ETP must be approved and documented in the client's file before the device is installed and prior to the service being authorized. Adds that services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to or receives from the Department of Children, Youth, and Families (DYYF) or from a Tribe in Washington State or from Title IV-E of the Social Security Act or from other sources. Please clarify whether individuals will not lose access to this service.

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

(1) Clinical and support needs for supported parenting services are identified in the waiver participant's DDA person-centered assessment and documented in her/his/their person-centered service plan.

(2) The State confirms that this service does not duplicate any coverage available on the state plan. This service does not overlap with the scope of another service. Supported Parenting is a distinct service with an unique billing code that is authorized separately from any other service.

(3) The dollar limitations in the waiver participant's annual allocation in the IFS Waiver limit the amount of supported parenting services she/he/they is authorized to receive as indicated in Appendix C-4.a.

(4) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Physical Therapist
Individual	Occupational Therapist
Agency	Speech/Language Pathologist
Agency	Nutritionist
Agency	Certified Dietician
Agency	Registered Nurse (RN) or Licensed Practical Nurse (LPN)
Individual	Certified American Sign Language Instructor
Agency	Psychiatrist
Individual	Mental Health Counselor
Individual	Providers listed in WAC 388-845-0506 (providers of Behavior Support and Consultation under the CIIBS Waiver) and contracted with DDA to provide CIIBS Intensive services.
Individual	Psychiatrist
Agency	Mental Health Counselor
Individual	Psychologist
Agency	Professional Advocacy Organization
Individual	Nutritionist
Individual	Counselors registered or certified in accordance with the requirements of Chapter 18.19 RCW
Individual	Speech/Language Pathologist
Agency	Occupational Therapist
Individual	Audiologist
Individual	Marriage and Family Therapist
Agency	Marriage and Family Therapist
Agency	Recreation Therapist registered in WA and certified by the National Council for Therapeutic Recreation
Individual	Certified Dietician
Agency	Audiologist
Individual	Recreation Therapist registered in WA and certified by the National Council for Therapeutic Recreation
Agency	Counselors registered or certified in accordance with the requirements of Chapter 18.19 RCW
Individual	Registered Nurse (RN) or Licensed Practical Nurse (LPN)
Agency	Certified American Sign Language Instructor
Individual	Social Worker
Agency	Psychologist
Individual	Physical Therapist
Agency	Social Worker
Agency	Providers listed in WAC 388-845-0506 (providers of Behavior Support and Consultation under the CIIBS Waiver) and contracted with DDA to provide CIIBS Intensive services.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Chapter 246-915 WAC (Department of Health administrative code concerning requirements for physical therapists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

RCW 18.59.050 (State law concerning licensure requirements for occupational therapists)

Chapter 246-847 WAC (Department of Health administrative code concerning requirements for occupational therapists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Speech/Language Pathologist

Provider Qualifications

License *(specify):*

Chapter 246-828-105 (Department of Health administrative code concerning speech-language pathology-minimum standards of practice)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Nutritionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 18.138 RCW (Washington state law concerning dietitians and nutritionists, including certification)

Chapter 246-822 WAC (Department of Health administrative code concerning certified dietitians and nutritionists)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Certified Dietician

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 18.138 RCW (State law concerning requirements for Dietitians and Nutritionists)

Chapter 246-822 WAC (DOH administrative code concerning requirements for Dietitians or Nutritionists)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Registered Nurse (RN) or Licensed Practical Nurse (LPN)

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning requirements for Practical and Registered Nursing)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Certified American Sign Language Instructor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification as an American Sign Language (ASL) Instructor

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Chapter 18.71 RCW (State law concerning requirements for Psychiatrists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Providers listed in WAC 388-845-0506 (providers of Behavior Support and Consultation under the CIIBS Waiver) and contracted with DDA to provide CIIBS Intensive services.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Chapter 18.71 RCW (State law concerning requirements for Psychiatrists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Chapter 246-924 WAC (Department of Health administrative code concerning requirements for psychologists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Professional Advocacy Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Nutritionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 18.138 RCW (Washington state law concerning dietitians and nutritionists, including certification)

Chapter 246-822 WAC (Department of Health administrative code concerning certified dietitians and nutritionists)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Counselors registered or certified in accordance with the requirements of Chapter 18.19 RCW

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-810 WAC (Department of Health administrative code concerning requirements for counselors)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Speech/Language Pathologist

Provider Qualifications

License *(specify):*

Chapter 246-828-105 (Department of Health administrative code concerning speech-language pathology-minimum standards of practice)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

RCW 18.59.050 (State law concerning licensure requirements for occupational therapists)

Chapter 246-847 WAC (Department of Health administrative code concerning requirements for occupational therapists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

Chapter 18.35 RCW Hearing and Speech Services and Chapter 246-828 WAC Hearing and Speech

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Marriage and Family Therapist

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Recreation Therapist registered in WA and certified by the National Council for Therapeutic Recreation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

National certification through the National Council for Therapeutic Recreation Certification.
Washington State Registration

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Certified Dietician

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 18.138 RCW (State law concerning requirements for Dietitians and Nutritionists)

Chapter 246-822 WAC (DOH administrative code concerning requirements for Dietitians or Nutritionists)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Audiologist

Provider Qualifications

License *(specify):*

Chapter 18.35 RCW Hearing and Speech Services and Chapter 246-828 WAC Hearing and Speech

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Recreation Therapist registered in WA and certified by the National Council for Therapeutic Recreation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

National certification through the National Council for Therapeutic Recreation Certification.
Washington State Registration

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Counselors registered or certified in accordance with the requirements of Chapter 18.19 RCW

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Chapter 246-810 WAC (Department of Health administrative code concerning requirements for counselors)

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Registered Nurse (RN) or Licensed Practical Nurse (LPN)

Provider Qualifications

License *(specify):*

Chapter 246-840 WAC (Department of Health administrative code concerning requirements for Practical and Registered Nursing)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Certified American Sign Language Instructor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification as an American Sign Language (ASL) Instructor

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Chapter 246-924 WAC (Department of Health administrative code concerning requirements for psychologists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Chapter 246-915 WAC (Department of Health administrative code concerning requirements for physical therapists)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

Chapter 246-809 WAC (Department of Health administrative code concerning licensure for mental health counselors, marriage and family therapists, and social workers)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Parenting

Provider Category:

Agency

Provider Type:

Providers listed in WAC 388-845-0506 (providers of Behavior Support and Consultation under the CIIBS Waiver) and contracted with DDA to provide CIIBS Intensive services.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications

Qualifications. In order to be qualified, providers of supported parenting services must have an understanding of the manner in which individuals with developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the licensed, registered or certified professionals listed below and be contracted with DDA.

Washington Administrative Code (WAC)

WAC 388-845-2135 Who are qualified providers of supported parenting services?
In order to be qualified, providers of supported parenting services must have an understanding of the manner in which persons with intellectual/developmental disabilities best learn in addition to skills in child development and family dynamics and be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Speech/language pathologist;
(9) Social worker;
(10) Psychologist;
(11) Certified American sign language instructor;
(12) Nutritionist;
(13) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(14) Certified dietician;
(15) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(16) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services; or
(17) Psychiatrist; or
(18) Professional advocacy organization.

When providing the service through teleservice delivery, the virtual platform must be HIPPA compliant. The provider must take measures necessary to ensure the HUB site (site where provider delivering the service is located during the time of service provision) maintains HIPPA and privacy standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Therapeutic Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Therapeutic adaptations are modifications to the environment necessary to reduce or eliminate environmental stressors, enable social support, or give a sense of control to the waiver participant in order for a therapeutic plan to be implemented. Adaptations include modifications such as:

- Noise reduction or enhancement
- Lighting Adjustment
- Wall Softening
- Tactile Accents
- Visual Accents

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

• One time adaptation every five years.
• Modifications may not add square footage to the home or convert nonliving space into living space.
• Requires a recommendation by a behavioral health provider, OT or PT within the waiver participant's current therapeutic plan.
• Therapeutic adaptations are not items covered under the Medicaid state plan including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
• The dollar limitations for the waiver participant's IFS Waiver annual allocation limit the amount of this service she/he/they is authorized to receive as indicated in Appendix C-4.a.

• The State notes that Therapeutic Adaptations is an unique and specific service that does not overlap with either Specialized Equipment and Supplies or Environmental Adaptations. Each service is authorized separately and has an unique billing code.

• Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Environmental Adaptation provider
Individual	Specialized Equipment and Supplies Vendor
Agency	Specialized Equipment and Supplies provider
Agency	Environmental adaptation provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Adaptations

Provider Category:
Individual
Provider Type:

Environmental Adaptation provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chapter 18.27 RCW (Washington state law concerning contractor registration)

Chapter 19.27 RCW (Washington state law concenring the state building code)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.
Contract language regarding provider qualifications.

2. Qualifications

The Contractor shall be currently registered as a general or specialty Contractor and in good standing with the Department of Labor and Industries under RCW 18.27, except as provided under TCW 18.27.090 Exemptions.

Washington Administrative Code (WAC)

WAC 388-845-0905 Who is a qualified provider for building these environmental adaptations?

The provider making these environmental adaptations must be a registered contractor per 18.27 RCW and contracted with DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Adaptations

Provider Category:

Individual

Provider Type:

Specialized Equipment and Supplies Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Adaptations

Provider Category:

Agency

Provider Type:

Specialized Equipment and Supplies provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Adaptations

Provider Category:

Agency

Provider Type:

Environmental adaptation provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chapter 18.27 RCW (Washington state law concerning contractor registration)

Chapter 19.27 RCW (Washington state law concenring the state building code)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.
Contract language regarding provider qualifications.

2. Qualifications

The Contractor shall be currently registered as a general or specialty Contractor and in good standing with the Department of Labor and Industries under RCW 18.27, except as provided under TCW 18.27.090 Exemptions.

Washington Administrative Code (WAC)

WAC 388-845-0905 Who is a qualified provider for building these environmental adaptations?

The provider making these environmental adaptations must be a registered contractor per 18.27 RCW and contracted with DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

• Service offered to enable participants to gain access to waiver and other community services, activities, and resources, as specified in their person-centered service plan.
• Waiver transportation is available if the cost and responsibility for transportation is not already included in the waiver participant provider's contract and payment.
• Waiver transportation services cannot duplicate other types of transportation available through the Medicaid state plan, EPSDT, or included in a provider's contract.
• Waiver transportation is different from Personal Care transportation in that it does not provide transportation to and from essential shopping or medical appointments. Whenever possible, the person will use family, neighbors, friends, or community agencies that can provide this service without charge.

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

• Service offered to enable participants to gain access to waiver and other community services, activities, and resources, as specified in their person-centered service plan.
• Waiver transportation is available if the cost and responsibility for transportation is not already included in the waiver participant provider's contract and payment.
• Waiver transportation services cannot duplicate other types of transportation available through the Medicaid state plan, EPSDT, or included in a provider's contract.
• Waiver transportation is different from Personal Care transportation in that it does not provide transportation to and from essential shopping or medical appointments. Whenever possible, the person will use family, neighbors, friends, or community agencies that can provide this service without charge.
• Since this service is one of the services covered under the budget allocation, an expenditure limitation applies as indicated in Appendix C-4.a.
• Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Public Transit
Agency	Transportation Provider
Individual	Transportation Provider
Agency	Non-Emergency Medical Transportation Companies
Agency	HCA Contracted Non-Emergency Medical Transportation Brokers
Agency	Taxis

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Public Transit

Provider Qualifications

License *(specify):*

Chapter 308-104 WAC (State administrative code concerning driver's licenses)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards; Chapter 308-106 WAC (State administrative code concerning mandatory insurance to operate a vehicle)

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Transportation Provider

Provider Qualifications

License *(specify):*

Chapter 308-104 WADC (Department of Licensing [DOL] administrative code concerning drivers' licenses)

Certificate *(specify):*

Other Standard *(specify):*

Chapter 308-106 WAC (State aministrative code concerning mandatory Insurance to operate a vehicle)

Chapter 308-106 WAC (State aministrative code concerning mandatory Insurance to operate a vehicle)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Agency contract language regarding provider qualifications.

3. Licenses, Registrations, and Certifications

a. The Contractor shall be licensed, registered, certified, and/or contracted as required by law.

b. The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by
RCW 43.20A.710. If the Contractor has employees or volunteers who will have unsupervised access to
Clients in the course of performing the work under this Contract, the Contractor will conduct criminal
history background checks on those employees.

Washington Administrative Code (WAC)

WAC 388-845-2205 Who is qualified to provide transportation services?

(1) The provider of transportation services can be an individual or agency contracted with DDA whose contract includes transportation in the statement of work.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Transportation Provider

Provider Qualifications

License *(specify):*

Chapter 308-104 WAC (Department of Licensing [DOL] administrative code concerning drivers' licenses)

Certificate *(specify):*

Other Standard *(specify):*

Chapter 308-106 WAC (State aministrative code concerning mandatory Insurance to operate a vehicle)

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications for individual providers.

a. The Contractor shall maintain all necessary licenses, registrations, and certifications as required by law. The Contractor agrees not to perform any task requiring a registration, certificate or license unless he/she is registered, certified or licensed to do so or is a member of the client's immediate family or is performing self-directed health care tasks. See RCW 18.679, 18.88A and 74.39 for laws related to nursing care, Registered Nurse Delegation, and self-directed health care tasks, respectively.

b. If the Contractors is providing Nurse Delegation Services, the Contractor must:

(1) Complete the Nurse Delegation for Nursing Assistants course and pass the competency test;

(2) Be a nursing assistant currently registered or certified;

(3) For Nursing Assistant Registereds, successfully complete Revised fundamentals of Caregiving, or
Modified Fundamentals of Caregiving; and

(4) Complete all Nurse Delegation training before performing any delegated task.

c. Prohibition of ALTSA/DDA employees contracting with DSHS to provide Individual Provider Services to DSHS long-term care clients.

If you are currently an Employee of ALTSA/DDA either with the
Developmental Disabilities Administration, Residential Care Services, or Home and Community services, or become an
employee of the same during the course of the period of this contract, you are considered disqualified and
DSHS will terminate your contract for convenience.

d. The Contractor shall meet all training requirements in WAC 388-71. DSHS shall supply the Contractor with training requirements and time frames for completion.

The Contractor agrees to undergo a criminal history background check conducted by DSHS, as required by RCW 43.20A.710.

Washington Administrative Code (WAC)

WAC 388-845-2205 Who is qualified to provide transportation services?

(1) The provider of transportation services can be an individual or agency contracted with DDA whose contract includes transportation in the statement of work.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Non-Emergency Medical Transportation Companies

Provider Qualifications

License *(specify):*

WAC 182-546-5000-6200 (State administrative code concerning non-emergency medical transportation); Chapter 308-104 WAC (State administrative code concerning driver's licenses)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards; Chapter 308-106 WAC (State administrative code concerning mandatory insurance to operate a vehicle)

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

HCA Contracted Non-Emergency Medical Transportation Brokers

Provider Qualifications

License *(specify):*

WAC 182-546-5000-6200 (State administrative code concerning non-emergency medical transportation); Chapter 308-104 WAC (State administrative code concerning driver's licenses)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards; Chapter 308-106 WAC (State administrative code concerning mandatory insurance to operate a vehicle)

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agecny

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Taxis

Provider Qualifications

License *(specify):*

Chapter 308-104 WAC (State administrative code concerning driver's licenses)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards; Chapter 308-106 WAC (State administrative code concerning mandatory insurance to operate a vehicle)

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adaptations or alterations to a vehicle that is the participant's primary means of transportation and is required in order to accommodate the unique needs of the waiver participant, enable full integration into the community, and ensure the health, welfare, and safety of the waiver participant and/or caregivers.

The following are specifically excluded:
• Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Vehicle Modifications require prior approval when over $550 from the DDA regional administrator or designee except for repairs to existing vehicle modifications.
Examples of vehicle modifications include:
a) Manual hitch-mounted carrier and hitch for all wheelchair types;
b) Wheelchair cover;
c) Wheelchair strap-downs;
d) Portable wheelchair ramps;
e) Accessible running boards and steps;
f) Assist poles and/or grab handles;
g) Power-activated carrier for all wheelchair types;
h) Permanently installed wheelchair ramps;
i) Repairs and maintenance to vehicle modifications as needed for client safety; and
j) Other access modifications.

The following vehicle modifications require prior approval by the DDA Regional Administrator or designee:
a) Power activated carrier for all wheelchair types;
b) Power activated wheelchair ramps;
c) Repairs and maintenance to vehicular modifications as needed for client safety; and
d) Other access modifications.

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

(1) Clinical and support needs for vehicle modification services are identified in the waiver participant's DDA person-centered assessment and documented in her/his/their person-centered service plan;
(2) The waiver participant lives in her/his/their family home;
(3) Prior approval by the regional administrator or designee is required except when under $550 or for repairs to existing vehicle modifications.
(4) Vehicle modifications are excluded if they are of general utility without direct medical or remedial benefit to the waiver participant;
(5) Participants who are enrolled with the Division of Vocational Rehabilitation (DVR) must pursue this benefit through DVR first;
(6) Vehicle modifications must be the most cost effective modification based upon a comparison of contractor bids as determined by DDA.
(7) Modifications will only be approved for a vehicle that serves as the waiver participant's primary means of transportation and is owned by the waiver participant and/or her/his/their family.
(8) DDA requires the waiver participant's treating professional's written recommendation regarding the need for the service. This recommendation must consider that the treating professional has recently examined the waiver participant, reviewed her/his/their medical records, and conducted a functional evaluation.
(9) The Department may require a second opinion from a department-selected provider that meets the same criteria as subsection 7) of this section.
(10) The dollar limitations of the waiver participant's annual allocation in the IFS Waiver limit the amount of vehicle modification service that the she/he/they is authorized to receive as indicated in Appendix C-4.a.
(11) Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vehicle Adaptive Equipment Vendor
Agency	Vehicle Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Vehicle Adaptive Equipment Vendor

Provider Qualifications

License *(specify):*

Chapter 19.02 RCW (Washington state law concerning business licenses)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.
2. Qualifications
a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized goods and services as outlined in
Attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with
DDA. Contractors located in the state of Washington must have a Universal Business Identifier and Master Business License, as issued by the state
Department of Revenue. Out of state contractors must possess a Universal Business Identifier and Master Business License only when it is required by
Washington State law.

b. Providers of specialized services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they
are providing.

Washington Administrative Code (WAC)

WAC 388-845-2265 Who are providers of vehicle modifications?

Providers of vehicle modifications are:
(1) Vehicle service providers contracted with DDA to provide this service; or
(2) Vehicle adaptive equipment vendors contracted with DDA to provide this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Vehicle Service Provider

Provider Qualifications

License *(specify):*

Chapter 19.02 RCW (Washington state law concerning business licenses)

Certificate *(specify):*

Other Standard *(specify):*

Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider qualifications.
2. Qualifications
a. The Contractor shall be a legal business entity legitimately engaged in the business of provision of specialized goods and services as outlined in
Attachment A. Vendors of specialized services must maintain a business license required by law for the type of product provided and contracted for with
DDA. Contractors located in the state of Washington must have a Universal Business Identifier and Master Business License, as issued by the state
Department of Revenue. Out of state contractors must possess a Universal Business Identifier and Master Business License only when it is required by
Washington State law.

b. Providers of specialized services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they
are providing.

Washington Administrative Code (WAC)

WAC 388-845-2265 Who are providers of vehicle modifications?

Providers of vehicle modifications are:
(1) Vehicle service providers contracted with DDA to provide this service; or
(2) Vehicle adaptive equipment vendors contracted with DDA to provide this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Operating Agency

Frequency of Verification:

Every 3 years.

The standard contract period is three years. If a component of a provider's qualification (e.g., license) expires prior to the standard three year contract period, the contract is set to expire in conjunction with the expiration of that component. If that component is subsequently renewed, and all other qualifications remain in place, the contract is renewed as well.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Wellness Education

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Wellness education provides waiver participants with monthly informational and educational materials designed to assist them in managing health related issues, achieving goals identified in their person-centered service plans and addressing health and safety issues. This service will assist participants to achieve greater health, safety and success in community living.
a. The individualized material is being developed by the state and by the contracted provider.
b. The participants will receive printed material.
c. The participants will receive a monthly mailing.
d. The Wellness Education service is designed to assist participants to live in the community and avoid institutionalization by ensuring that they receive needed information and tools. For example, the service can provide

information needed to:
• Successfully manage chronic conditions in order to halt progression resulting in risk of nursing home placements;

• Prevent and avoid health risks such as, pneumonia, influenza, infections, and other illnesses or conditions that can lead to nursing home placement for elderly or frail participants;
• Work effectively with health providers in order to understand and follow recommendations for the correct course of treatment in order to prevent hospitalization or nursing home placement;
• Develop support networks that can promote engagement and combat isolation that can lead to increased health and safety risks that can result in nursing home placement;
• Develop an effective person-centered service plan that utilizes an array of paid or informal supports to address the whole person needs of the person to live successfully in the community;
• Achieve community goals identified in the person-centered service plan.

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

Waiver participants who elect to receive this waiver service will receive the service monthly.
Since this service is one of the services covered under the annual allocation, an expenditure limitation applies as indicated in Appendix C-4.a.
Payment will be made directly to the provider by the State Medicaid Agency.

Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Wellness Education

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Education

Provider Category:

Agency

Provider Type:

Wellness Education

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Wellness Education newsletter is published and mailed by an agency with experience managing, developing and distributing monthly newsletters to a specified population.
The State clarifies that this service provider must adhere to WAC 388-845-2290.
Contract Standards. All DDA/DSHS contracts include the following standards: contract definitions, contract purpose, provider qualifications, statement of work, consideration, billing and payment process, background check process, drug free workplace, duty to report suspected abuse, duty to report unusual incidents and contract dispute resolution process.

Contract language regarding provider requirements. The Contractor shall:

1. Create an introductory newsletter available to DSHS in PDF, translated into all seventeen (17) languages to be used by DSHS when new clients enroll in the waiver mid-month and need to access the Wellness Education service.
2. Produce a monthly client newsletter with simple to understand information and specific action items to address whole wellness and safety needs identified in the Clients' service plan. Each Client's newsletter will contain three (3) articles that educate the Client on relevant aspects of lifestyle, health education or clinical management.

Washington Administrative Code (WAC)

WAC 388-845-2290 Who are qualified providers of wellness education? The wellness education provider must have the ability and resources to:
1) Receive and manage client data in compliance with all applicable federal HIPPA regulations, state law and rules and ensure client confidentiality and privacy;
2) Translate materials into the preferred language of the participant;
3) Ensure that materials are targeted to the participant's assessment and person-centered service plan;
4) Manage content sent to participants to prevent duplication of materials;
5) Deliver newsletters and identify any undeliverable client/representative addresses prior to each monthly mailing and manage any returned mail in a manner that ensures participants receive the monthly information; and
6) Contract with ALTSA or DDA to provide this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

Frequency of Verification:

Every two years.

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☒ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

State-employed DDA Case Resource Managers and DDA Social Service Specialists conduct case management functions on behalf of waiver recipients.

Appendix C: Participant Services

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

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

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

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

(a) Background checks are required for providers who have unsupervised access to individuals with developmental disabilities receiving services on the IFs Waiver. This includes volunteers, students, interns, or contracted or licensed staff and state staff.
(b) Searches are conducted through Washington State Patrol, and all long-term care workers (as defined below) are required to have a fingerprint check through the FBI. Individuals being hired by DDA who have lived in Washington less than three years are also required to have a fingerprint check through the FBI. As of January 2016, staff hired by Supported Living providers will also have to undergo a fingerprint check through the FBI.

The DSHS Background unit also checks Adult Protective Services and Department of Health registers.

State and federal (FBI) background checks were required for all long-term care workers (as defined in RCW 74.39A.009) for the elderly or persons with disabilities. "Long-term care workers" includes all persons who provide paid, hands-on personal care services for the elderly or persons with disabilities, including but not limited to individual providers of home care services, direct care workers employed by home care agencies, providers of home care services to persons with developmental disabilities under Title 71A RCW, all direct care workers in state-licensed assisted living facilities, and adult family homes, respite care providers, direct care workers employed by community residential service businesses, and any other direct care worker providing home or community-based services to the elderly or persons with functional disabilities or developmental disabilities.
(c) The entity responsible for retrieving this information is DSHS/Background Check Centralized Unit (BCCU).
(d) Relevant state laws, regulations and policies are: RCW 43.43.837 (State Patrol Washington State law concerning fingerprint-based background checks)-, RCW 74.15.030(c) (public assistance Washington state law concerning background checks for those with unsupervised access to children or individuals with a developmental disability), WAC 388-06 (DSHS administrative code concerning background checks)and DSHS Administrative Policy 18.63 (concerning employee background check requirements).

State utilizes multiple processes and QA oversight to ensure that mandatory investigations have been conducted in accordance with state policy. All state, county and contractor employees, volunteers and interns who have direct contact with waiver participants must have evidence of background investigations completed with a non-disqualifying check result in their personnel files. State and county staff who complete contracts for all contractors require evidence of completed background investigations with a non-disqualifying check result before contracts are signed and put into effect. State residential QA staff utilize a DDA residential background check tracking tool to document that all contract residential staff have completed background investigations with a non-disqualifying result. Residential Care Services licensors and certifiers review evidence of completed background investigations while conducting initial and renewal licensing/certification of all residential providers.

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

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

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

(a) The entities responsible for maintaining the abuse registry:

Under state authority, RCW 26.44 (state law concerning abuse of children), Child Protective Services (CPS) within the Department of Children, Youth and Families is responsible for receiving and investigating reports of suspected child abuse and neglect.

Under state authority, RCW 74.34 (state law concerning abuse of vulnerable adults), the Aging and Long Term Support Administration (ALTSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Developmental Disabilities Administration. ALTSA Residential Care Services (RCS) investigates provider practice issues with respect to abuse and neglect occurring in nursing homes, assisted living facilities, adult family homes, & supported living programs. ALTSA Adult Protective Services (APS) investigates abuse and neglect involving adults residing in residential facilities and in their own homes. Both APS and RCS forward final findings of abuse, neglect and exploitation to the DSHS Background Check Central Unit (BCCU).

The BCCU enters the information into a database used to screen all names submitted for a background check.

(b) The types of positions for which abuse registry screenings must be conducted:

Pursuant to WAC 388-06-0110 (concerning who must have background checks) and RCW 74.15.030 (state law concerning the powers and duties of the Secretary of DSHS, including background checks), all DDA direct hires and direct contracts which may involve unsupervised access to children or people with developmental disabilities require a background check through the BCCU which includes abuse registry screening.

Prior to providing contracted waiver services, the DSHS requires screening of individuals through the BCCU which includes the abuse registry findings. Per RCW 74.39A.050(8)(state law concerning quality improvement of long-term care services), no provider or staff, or prospective provider or staff, entered into a state registry finding him or her guilty of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in Chapter 74.34 RCW (state law concerning abuse of vulnerable adults) shall be employed in the care of and have unsupervised access to vulnerable adults.

(c) The process for ensuring that mandatory screenings have been conducted:

As part of the background check process, the BCCU cross-checks all potential employees with a CA database that contains information on all individuals with a substantiated finding of child abuse and/or neglect. DDA does not hire or contract with any provider that may have unsupervised contact with a child or vulnerable adult until a background check is cleared and placed into the individual's file (DDA Policy 5.01, Background Checks). Contracted agency providers are required to conduct background checks on all of their employees, including all administrators, employees, volunteers, and subcontractors who may have unsupervised access to clients, pursuant to WAC 388-101-3250 (concerning background checks for the staff of certified provides of community residential services and supports) and RCW 43.43.830 (which is state law covering the Washington State Patrol which concerns background checks for those with access to children or vulnerable adults). This is checked again by the state during contract renewal no less than every 3 years.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may

not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

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

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

- ☐ **Self-directed**
- ☐ **Agency-operated**

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

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

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

State regulations stipulate the following limitations apply to providers for waiver services:

(1) The waiver participant's spouse cannot be their paid provider for any waiver service.

(2) If the individual is under age eighteen, her/his/their natural, step, or adoptive parent cannot be the paid provider for any waiver service.

(3) If the individual is age eighteen or older, her/his/their natural, step, or adoptive parent cannot be the paid provider for any waiver service with the exception of:

(a) Transportation to a waiver service and nonmedical services in the community identified in your person-centered service plan;

(b) Residential Habilitation services if her/his/their parent is certified as a residential agency; or

(c) Respite care for the individual if she/he/they and her/his/their parent live in separate households.

Any relative or legal guardian who does not meet any of the three criteria detailed in this section may be qualified to furnish services.

The following controls are in place to ensure payments are made only for services rendered:

- Annual Person-Centered Service Plans
- Case resource manager monitoring of plan
- Annual PCSP audits
- National Core Indicator interviews
- Person-Centered Service Plan surveys

To ensure the safety of waiver participants, the state instructs Case Resource Managers to locate a third party to supervise providers when the waiver participant is unable to do so.

Waiver services for which payment may be made to relatives or legal guardians include: 1) respite; 2) stabilization services – crisis diversion bed; 3) community engagement; 4) environmental adaptations; 5) occupational therapy; 6) physical therapy; 7) skilled nursing; 8) specialized equipment and supplies; 9) speech, hearing and language services; 10) Staff/family consultation; and 11) transportation.

There are no limitations on the amount of services that may be furnished by a relative or legal guardian (above and beyond limitations described in waiver services or Appendix C-4).

Legal guardians who exercise decision-making authority may be paid to provide waiver services. Case/Resource Managers work with the waiver participant and waiver participant’s family to develop a person-centered service plan that meets the needs of the waiver participant and honors the preferences of the waiver participant based on needs identified in the DDA Assessment. As a component of this person-centered service plan development, waiver participants are offered a choice of service providers.

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

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

○ **Other policy.**

Specify:

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

The State of Washington allows for continuous open enrollment of all qualified providers. Provider qualifications are available to the public on-line per Washington Administrative Code (WAC). Waiver enrollees may select qualified providers at any time during the waiver year. Providers may enroll at any time during the year.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
C.a.1. # & % of wvr serv providers requiring licensure or certification, which initially met and continued to meet all DDA contract standards, including lic or cert, prior to furnishing services N = # of wvr serv prvdrs requiring lic or cert, which initially met & continued to meet all DDA cntrt stds, including lic or cert, prior to furnishing svs D= All wvr svs prvdrs that require lic or cert

Data Source (Select one):
Other
If 'Other' is selected, specify:
Agency Contracts Database (ACD)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

requirements.

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

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

Performance Measure:
C.b.1. Number & percent of waiver participant files with all authorized non-licensed/non-certified providers that met DDA contract standards and waiver requirements. N = # of waiver participant files with all authorized non-licensed/non-certified providers that met DDA contract standards and waiver requirements. D = All waiver participant files reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

Performance Measure:
C.c.3: The number and percent of non-licensed/non-certified waiver providers who met state and waiver training requirements as verified by state policies and procedures. N = Number of non-licensed/non-certified waiver providers who met

state and waiver training requirements as verified by state policies and procedures. D = All non-licensed/non-certified waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Agency Contracts Database (ACD)

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.c.2: # & % of licensed/certified waiver service providers who met state & waiver training requirements as verified by state policies & procedures. N = # of licensed/certified wvr svs providers who met state & waiver training requirements as verified by state policies & procedures. D = All licensed/certified wvr svs providers requiring licensure/certification & state & waiver training.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Agency Contracts Database (ACD)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

C.a.1 and C.c.2: The Contracts Program Manager produces an annual report comparing claims data against the Agency Contracts Database (ACD) to verify that providers of service to all waiver participants meet contract standards, including licensure and other requirements, as verified by a valid contract.

C.c.2 and C.c.3: DDA maintains provider contract records in the Agency Contracts Database (ACD) that verifies providers have met ongoing training requirements prior to contract renewal. ACD reports are run annually to verify completion of training requirements.

C.b.1: The Quality Compliance Coordinator (QCC) Team completes a review of randomly selected files across all waivers on an annual basis. The list for the QCC Team review is generated to produce a random sample with a 95% confidence level with a margin of error of +/-5%. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.
As a part of the QCC review, the team checks to see that providers of service to waiver participants continue to meet contract standards, which include appropriate licensure, certification and other standards including training requirements, as verified by a valid contract in the Agency Contracts Database.

b. Methods for Remediation/Fixing Individual Problems

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

Contract Reports: C.a.1; C.c.2; and C.c.3:
The results of the annual report comparing claims data against the ACD are shared with the regions for immediate follow up. Providers without a valid contract or the necessary training requirements are reviewed to determine the appropriate course of contract action. Services are terminated for those without valid contracts.

QCC Waiver File Reviews: C.b.1:
Individual findings are expected to be corrected within 90 days. Regional management and QCC are available to provide individualized support and assistance with these corrections. QCC staff monitors to ensure corrections occur.
Next, findings are analyzed by DDA management. Based on the analyses, additional necessary steps are taken. For example:

- Annual staff Waiver Training curriculum is developed and/or modified.
- Policies are clarified.
- Personnel issues are identified and addressed.
- Form format and instructions are modified.
- Waiver administrative code (WAC) is revised.
- Regional processes are revised.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

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

Furnish the information specified above.

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

a.) The limits apply to all waiver services except stabilization services and risk assessments.
State reviewed expenditure data for the state-funded IFS program prior to submitting the original IFS waiver application in 2015. Benefit levels for the IFS waiver were derived from the State-only funded IFS Program and were established as directed by the State Legislature to mirror the State-only IFS Program benefit levels. CMS 372 Annual Per Capita (APC) expenditures for waiver services were $954 for 2015-2016, $1,006 for 2016-2017 and $1,047 for 2017-2018 (Draft CMS 372) demonstrate that these benefit levels are sufficient to assure the health and welfare of the target population post entrance to the waiver. State will reevaluate benefit levels during the five year waiver cycle based on annual CMS 372 APC data and propose changes as necessary to the Washington Legislature and to CMS.

b.) The IFS limits are determined based on an assessment of need. The annual allocations are:
- Level 1 - $1,560;
- Level 2 - $2,340;
- Level 3 - $3,120;
- Level 4 - $4,680.

Historically the limits have been based upon funding provided by the Legislature and extensive data indicating a high relationship between assessed need, funding level and avoidance of out-of-home placement. Individuals with needs that exceed IFS funding levels have historically been placed on one of DDA's other HCBS waivers (ie., Basic Plus, Core, Community Protection, Children's Intensive In-Home Behavioral Support-CIIBS.)

The allocation of funding is based upon the DDA individual and family services assessment, which is an algorithm in the DDA assessment that determines the individual award level using the assessed support levels from:
The purpose of the individual and family services assessment is to determine your individual and family services level and score using your assessed support levels from:
(1) The DDA protective supervision acuity scale;
(2) The DDA caregiver status acuity scale;
(3) The DDA behavioral acuity scale;
(4) The DDA medical acuity scale; and
(5) The DDA activities of daily living (ADL) acuity scale.

The IFS services level is determined according to the following table:

(1) DDA determines your individual and family services level using the following table:

If your protective supervision support level is: And your primary caregiver risk level is: And your backup caregiver risk score is: And your behavioral acuity level is: Then your unadjusted individual and family services level is:

Table 1

If the protective supervision support level is:	And the primary caregiver risk level is:	And the backup caregiver risk score is:	And the behavioral acuity level is:	Then the adjusted individual and family services level is:
0	None	1	None	1
0	None	1	Low	1
0	None	1	Medium	1
0	None	1	High	2
0	None	2 or 3	None	1
0	None	2 or 3	Low	1
0	None	2 or 3	Medium	2
0	None	2 or 3	High	2
0	Low	1	None	1
0	Low	1	Low	1
0	Low	1	Medium	1
0	Low	1	High	2

0	Low	2 or 3	None	1
0	Low	2 or 3	Low	1
0	Low	2 or 3	Medium	2
0	Low	2 or 3	High	2
0	Medium	1	None	1
0	Medium	1	Low	1
0	Medium	1	Medium	1
0	Medium	1	High	2
0	Medium	2 or 3	None	1
0	Medium	2 or 3	Low	1
0	Medium	2 or 3	Medium	2
0	Medium	2 or 3	High	2
0	High	1	None	1
0	High	1	Low	1
0	High	1	Medium	2
0	High	1	High	2
0	High	2 or 3	None	2
0	High	2 or 3	Low	2
0	High	2 or 3	Medium	2
0	High	2 or 3	High	3
0	Immediate	1	None	1
0	Immediate	1	Low	1
0	Immediate	1	Medium	2
0	Immediate	1	High	2
0	Immediate	2 or 3	None	2
0	Immediate	2 or 3	Low	2
0	Immediate	2 or 3	Medium	2
0	Immediate	2 or 3	High	3
1	None	1	None	1
1	None	1	Low	1
1	None	1	Medium	1
1	None	1	High	2
1	None	2 or 3	None	1
1	None	2 or 3	Low	1
1	None	2 or 3	Medium	2
1	None	2 or 3	High	3
1	Low	1	None	1
1	Low	1	Low	1
1	Low	1	Medium	1
1	Low	1	High	2
1	Low	2 or 3	None	1
1	Low	2 or 3	Low	1
1	Low	2 or 3	Medium	2
1	Low	2 or 3	High	3
1	Medium	1	None	1
1	Medium	1	Low	1
1	Medium	1	Medium	2
1	Medium	1	High	3
1	Medium	2 or 3	None	1
1	Medium	2 or 3	Low	2
1	Medium	2 or 3	Medium	2
1	Medium	2 or 3	High	3
1	High	1	None	2
1	High	1	Low	2
1	High	1	Medium	2
1	High	1	High	3
1	High	2 or 3	None	2

1	High	2 or 3	Low	2
1	High	2 or 3	Medium	3
1	High	2 or 3	High	4
1	Immediate	1	None	2
1	Immediate	1	Low	2
1	Immediate	1	Medium	2
1	Immediate	1	High	3
1	Immediate	2 or 3	None	2
1	Immediate	2 or 3	Low	2
1	Immediate	2 or 3	Medium	3
1	Immediate	2 or 3	High	4
2 or 3	None	1	None	1
2 or 3	None	1	Low	1
2 or 3	None	1	Medium	2
2 or 3	None	1	High	3
2 or 3	None	2 or 3	None	2
2 or 3	None	2 or 3	Low	2
2 or 3	None	2 or 3	Medium	2
2 or 3	None	2 or 3	High	4
2 or 3	Low	1	None	1
2 or 3	Low	1	Low	1
2 or 3	Low	1	Medium	2
2 or 3	Low	1	High	3
2 or 3	Low	2 or 3	None	2
2 or 3	Low	2 or 3	Low	2
2 or 3	Low	2 or 3	Medium	2
2 or 3	Low	2 or 3	High	4
2 or 3	Medium	1	None	2
2 or 3	Medium	1	Low	2
2 or 3	Medium	1	Medium	2
2 or 3	Medium	1	High	3
2 or 3	Medium	2 or 3	None	2
2 or 3	Medium	2 or 3	Low	2
2 or 3	Medium	2 or 3	Medium	3
2 or 3	Medium	2 or 3	High	4
2 or 3	High	1	None	2
2 or 3	High	1	Low	2
2 or 3	High	1	Medium	2
2 or 3	High	1	High	3
2 or 3	High	2 or 3	None	2
2 or 3	High	2 or 3	Low	2
2 or 3	High	2 or 3	Medium	3
2 or 3	High	2 or 3	High	4
2 or 3	Immediate	1	None	2
2 or 3	Immediate	1	Low	2
2 or 3	Immediate	1	Medium	2
2 or 3	Immediate	1	High	3
2 or 3	Immediate	2 or 3	None	2
2 or 3	Immediate	2 or 3	Low	2
2 or 3	Immediate	2 or 3	Medium	3
2 or 3	Immediate	2 or 3	High	4
4	None	1	None	2
4	None	1	Low	2
4	None	1	Medium	2
4	None	1	High	3
4	None	2 or 3	None	2
4	None	2 or 3	Low	2

4	None	2 or 3	Medium	3
4	None	2 or 3	High	4
4	Low	1	None	2
4	Low	1	Low	2
4	Low	1	Medium	2
4	Low	1	High	3
4	Low	2 or 3	None	2
4	Low	2 or 3	Low	2
4	Low	2 or 3	Medium	3
4	Low	2 or 3	High	4
4	Medium	1	None	2
4	Medium	1	Low	2
4	Medium	1	Medium	3
4	Medium	1	High	3
4	Medium	2 or 3	None	2
4	Medium	2 or 3	Low	3
4	Medium	2 or 3	Medium	3
4	Medium	2 or 3	High	4
4	High	1	None	2
4	High	1	Low	2
4	High	1	Medium	3
4	High	1	High	3
4	High	2 or 3	None	2
4	High	2 or 3	Low	3
4	High	2 or 3	Medium	4
4	High	2 or 3	High	4
4	Immediate	1	None	2
4	Immediate	1	Low	2
4	Immediate	1	Medium	3
4	Immediate	1	High	3
4	Immediate	2 or 3	None	2
4	Immediate	2 or 3	Low	3
4	Immediate	2 or 3	Medium	4
4	Immediate	2 or 3	High	4
5	None	1	None	2
5	None	1	Low	2
5	None	1	Medium	3
5	None	1	High	4
5	None	2 or 3	None	3
5	None	2 or 3	Low	3
5	None	2 or 3	Medium	4
5	None	2 or 3	High	5
5	Low	1	None	2
5	Low	1	Low	2
5	Low	1	Medium	3
5	Low	1	High	4
5	Low	2 or 3	None	3
5	Low	2 or 3	Low	3
5	Low	2 or 3	Medium	4
5	Low	2 or 3	High	5
5	Medium	1	None	2
5	Medium	1	Low	2
5	Medium	1	Medium	3
5	Medium	1	High	4
5	Medium	2 or 3	None	3
5	Medium	2 or 3	Low	3
5	Medium	2 or 3	Medium	4

5	Medium 2 or 3 High 5
5	High 1 None 2
5	High 1 Low 2
5	High 1 Medium 3
5	High 1 High 4
5	High 2 or 3 None 3
5	High 2 or 3 Low 3
5	High 2 or 3 Medium 4
5	High 2 or 3 High 5
5	Immediate 1 None 2
5	Immediate 1 Low 2
5	Immediate 1 Medium 3
5	Immediate 1 High 4
5	Immediate 2 or 3 None 3
5	Immediate 2 or 3 Low 3
5	Immediate 2 or 3 Medium 4
5	Immediate 2 or 3 High 5
6	None 1 None 2
6	None 1 Low 3
6	None 1 Medium 3
6	None 1 High 4
6	None 2 or 3 None 3
6	None 2 or 3 Low 3
6	None 2 or 3 Medium 4
6	None 2 or 3 High 5
6	Low 1 None 2
6	Low 1 Low 3
6	Low 1 Medium 3
6	Low 1 High 4
6	Low 2 or 3 None 3
6	Low 2 or 3 Low 3
6	Low 2 or 3 Medium 4
6	Low 2 or 3 High 5
6	Medium 1 None 3
6	Medium 1 Low 3
6	Medium 1 Medium 3
6	Medium 1 High 4
6	Medium 2 or 3 None 3
6	Medium 2 or 3 Low 4
6	Medium 2 or 3 Medium 4
6	Medium 2 or 3 High 5
6	High 1 None 3
6	High 1 Low 3
6	High 1 Medium 4
6	High 1 High 4
6	High 2 or 3 None 4
6	High 2 or 3 Low 4
6	High 2 or 3 Medium 5
6	High 2 or 3 High 5
6	Immediate 1 None 3
6	Immediate 1 Low 3
6	Immediate 1 Medium 4
6	Immediate 1 High 4
6	Immediate 2 or 3 None 4
6	Immediate 2 or 3 Low 4
6	Immediate 2 or 3 Medium 5
6	Immediate 2 or 3 High 5

(2) DDA adds one level to the individual and family services level when the individual and family services level is determined to be:
(a) Level one, two, three, or four; and
Continued at Main. B Optional

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

Washington State assessed and verified that the settings proposed for this waiver are settings that are home and community-based as defined at 42 CFR 441.301(c)(4). No excluded settings are included in the IFS waiver settings.

Washington State will ensure that all settings, including any future new settings, will continue to comport with the HCBS settings regulations by a comprehensive system of settings reviews and HCBS settings compliance verifications including but not limited to:

(1) waiver file review – performance measure C.b.1 The percentage of waiver files reviewed for which all authorized providers met DDA and HCBS settings standards. N = All files reviewed for which 100% of authorized providers met contract and HCBS settings standards. D = All files reviewed for compliance with contract and HCBS settings standards;

(2) annual on-site reviews of the following settings: (a) In-home – case resource managers visit these settings annually; (b) Community healthcare providers – annual quality assurance monitoring cycle; (c) Dental providers – annual quality assurance monitoring cycle; (d) Specialized psychiatric services – annual quality assurance monitoring cycle; (e) Positive behavior support and consultation – annual quality assurance monitoring cycle; (f) Community crisis stabilization services – annual quality assurance monitoring cycle; (g) Vehicle modification providers – annual quality assurance monitoring cycle; (h) Adult day services – reviewed by Area Agencies on Aging; (i) Adult residential treatment facility – reviewed by Department of Health as part of licensure process;

(3) annual or biannual on-site reviews of the following settings as part of the licensure process: (a) Adult family home – Residential Care Services, Department of Social and Health Services; (b) Adult residential care facility – Residential Care Services, Department of Social and Health Services;

(4) biannual on-site reviews of the following settings as part of the certification process: (a) group home – Residential Care Services, Department of Social and Health Services;

(5) Every three year review of the following settings by regional DDA staff at the time of contract renewal: (a) transportation providers; (b) environmental adaptations providers; (c) specialized clothing providers; (d) Staff/family consultation and training providers; (e) skilled nursing providers; (f) assistive technology providers; (g) peer mentoring providers; (h) person-centered planning facilitation providers; (i) supported parenting providers; (j) community engagement providers; (k) senior centers; (l) child day care centers; (m) community centers; (n) summer programs; (o) parks and recreation programs;

6) Every three year on-site review as part of the licensing process by the Division of Licensed Resources, Department of Children, Youth and Families of the following settings: (a) licensed staffed residential; (b) child foster care; and (c) child group care facilities.

(6) DDA reviewed the requirements for HCBS settings and identified all IFS waiver settings as fully complying with the HCBS requirements. DDA's review included an analysis of state laws, rules, policies, processes, and forms/tools in relation to the new federal HCBS requirements.

DDA reviewed and documented that the following IFS waiver service settings are compliant with HCBS settings rules:

- In home – all IFS waiver participant live in their own private homes
- Behavioral Health Stabilization Services - Crisis Diversion Bed Services
- Community healthcare providers – provided in provider's office
- Dental providers – provided in provider's office in a typical community setting site - see additional documentation at the end of this section
- Specialized psychiatric services – provided in provider's office in a typical community setting
- Positive behavior support and consultation – provided in home or in provider's office in a typical community setting
- Vehicle modification providers – provided in provider's shop in a typical community setting
- Transportation providers – provided in the community

Based on an analysis of state laws, rules, policies, processes, and forms/tools in relation to the new federal HCBS requirements, DDA also verified that the following additional IFS waiver service settings are also fully compliant with HCBS setting rules:

- Environmental adaptations – provided in home
- Specialized clothing – provided in the community
- Staff/family consultation and training – provided in provider's office in a typical community setting
- Skilled nursing – provided in home
- Assistive technology – provided in home and in provider's office in a typical community setting
- Peer mentoring – provided in home and in the community

- Person-centered planning facilitation – provided in home
- Supported parenting service – provided in home and in provider's office in a typical community setting
- Community engagement – provided in the community

Respite care settings

- Respite - provided in the community in the following integrated settings: In-home, senior center, child day care center, community center, child care center
- Respite - provided in the following settings determined to be compliant with HCB setting requirements: group home, licensed staffed residential program, adult day services, child foster care and child group care facilities
- Respite - provided in settings that with changes will fully comply with HCB setting requirements: Adult family home, adult residential care facility
- Respite - provided in a setting that may require changes to fully comply with HCB setting requirements: Adult residential treatment facility
- Respite - provided in settings that may be segregated: Summer program, parks and recreation program

(7) DDA will periodically review services under the IFS Waiver to ensure that home and community-based setting requirements continue to be met. The results of those reviews will be shared with the Medicaid Agency Management Committee which includes representatives from the Health Care Authority (the single State Medicaid Agency).

The following settings are reviewed annually:

- In home – case resource managers visit these settings annually.
- Behavioral Health Stabilization Services - Crisis Diversion Bed Services
- Stabilization Services - Crisis Diversion Bed
- Community healthcare providers – annual Quality Assurance monitoring cycle.
- Dental providers – annual Quality Assurance monitoring cycle.
- Specialized psychiatric services – annual Quality Assurance monitoring cycle.
- Positive behavior support and consultation – annual Quality Assurance monitoring cycle.
- Vehicle modification providers – annual Quality Assurance monitoring cycle.
- Adult day services (by Area Agencies on Aging)
- Adult residential treatment facility (by the Department of Health as part of licensure)

The following settings are reviewed annually or every two years as part of the licensure process:

- Adult family home (two years, Department of Social and Health Services)
- Adult residential care facility (two years, Department of Social and Health Services)
- Adult residential treatment facility (annually, Department of Health)

The following settings are reviewed at least every two years by Residential Care Services as part of the certification process:

- Group Home

The following settings are reviewed at least every three years by regional staff at the time of contract renewal:

- Transportation providers
- Environmental adaptations
- Specialized clothing
- Staff/family consultation
- Skilled nursing
- Assistive technology
- Peer mentoring
- Person-centered planning facilitation
- Sexual Safety Therapy
- Supported parenting service
- Community engagement
- Senior centers
- Child day care center
- Community centers
- Child care centers
- Summer programs
- Parks and recreation programs

The following settings are reviewed as part of the licensing process at least every three years by the Division of Licensed

Resources (DLR) staff of the Department of Children, Youth and Families:

- Licensed Staffed Residential
- Child Foster Care
- Child Group Care Facilities

When non-compliant settings are found, the State utilizes one or more of the following processes to remediate the situation: 1) for licensed and certified providers, State may utilize the license/certification remediation process specified in rule (WAC 388-101-3160); 2) for all state-contracted providers, State may use contractual remediation steps contained in contractual agreements between the State and service providers; 3) for county contracted providers, counties may use contractual remediation steps contained in contractual agreements between the county and service providers; and 4) for residential, employment and day program providers, State may utilize technical assistance resources to consult with and bring non-compliant settings into compliance.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Regional DDA Case/Resource Managers and Regional DDA Social Service Specialists are responsible for development of the person-centered service plan (PCSP). In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory waiver training prior to completing any evaluations.

DDA Case/Resource Manager
Minimum Qualifications:
A Bachelor's degree in social sciences, social services, human services, behavioral sciences or an allied field and two years of experience providing social services to people with intellectual or developmental disabilities. OR
6 years of experience in providing social services to people with intellectual or developmental disabilities. OR
Satisfactory completion of 12 months as a Case Resource Manager Trainee. OR
Equivalent experience/education.

☒ **Social Worker**
Specify qualifications:

Social Service Specialist
Minimum Qualifications
A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience.
OR
A Bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years of social service experience.
OR
Seven years of professional experience and/or related education in providing social services to people with intellectual or developmental disabilities.

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Approximately 60 days prior to the Person-Centered Service Plan (PCSP) meeting, the Case Resource Manager(CRM)/Social Service Specialist contacts the individual and his/her/their representative by phone and letter. To aid them in their assessment planning and scheduling, case resource managers and their supervisors run monthly caseload reports that show each individual's next PCSP date.

During the phone conversation the CRM/Social Service Specialist describes the Person-Centered Service Plan process. The CRM/Social Service Specialist also confirms who the participant wants present at their person-centered planning meeting and whether anyone participating will be acting as their representative, if they choose to have a representative. In addition, the individual is asked where and when they would like the PCSP meeting to be held. Support is provided as needed to ensure the service plan development process is driven by the waiver participant.

Participants are not required to have a representative to participate in any waiver. Participants are not and will not be denied entry into a waiver or disenrolled from a waiver if the individual does not have a representative or does not agree to have a representative.

The letter the CRM/Social Service Specialist sends serves to confirm the date, time and location of the meeting and includes the DDA HCBS Waiver Brochure. The DDA HCBS Waiver Brochure includes information about waiver services, eligibility criteria and administrative hearing rights. The CRM/Social Service Specialist also extends invitations by phone and/or letter to individuals who the waiver participant has asked to participate in the PCSP process. In addition, the waiver participant is provided access to person centered planning tools that they can review and use prior to the meeting. Support is available to assist the individual to review and/or use those tools.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

State requires an annual reassessment and State provides participants notice in advance of their next PCSP date so the assessment may be scheduled at a time that is convenient to the participant (WAC 388-828-1500). DDA assessments are administered at a location and in a way that is convenient to the participant (WAC 388-828-1520). If the participant receives a DDA-paid service in their home and the DDA assessment is not administered in the home, DDA will conduct a follow-up home visit to ensure that the participant's person-centered service plan can be safely implemented in their residential environment.

The Person-Centered Service Plan (PCSP) is the planning document produced for all clients receiving paid services, including waiver clients and is developed in accordance with the 42 CFR §441.301(2), which requires the Person-Centered Service Plan to:

- Reflect that the setting in which the individual resides is chosen by the individual or legal decision maker;
- Be understandable to the individual receiving services and the individuals important in supporting him/her/them;
- Be finalized and agreed to with the informed consent of the individual in writing and signed by all individuals and providers responsible for its implementation;
- Be distributed to the individual and other people involved in the plan;
- Include those services, the purpose or control of which the individual elect to self-direct;
- Document the positive interventions and supports used prior to any modifications to the Person-Centered Service Plan;
- Document less intrusive methods of meeting the need that have been tried but did not work;
- Include a clear description of the condition that is directly proportionate to the specific assessed need;
- Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- Include an assurance that interventions and supports will cause no harm to the individual;
- Document the frequency with which the plan will be reviewed and revised upon reassessment of functional need by §441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

The DDA Assessment provides:

- An integrated, comprehensive tool to measure support needs for adults and children.
- An improved work process to support case management services because the system:
  - o Identifies the level of support needed by a client;
  - o Indicates whether a service level assessment is needed; and
  - o Identifies a level of service to support the client's assessed need.
- Detailed information is gathered regarding client needs in many life domains. This allows CRMs to make more effective service referrals.
- Health and welfare needs identified in the assessment automatically populate the PCSP as needs that must be addressed.
- Clearer information for executive management and legislators on the overall needs of people with developmental disabilities.
- A nationally normed assessment (Supports Intensity Scale) for adults developed by the American Association on Intellectual and Developmental Disabilities.

(a) Who develops the plan, who participates in the process, and the timing of the plan.

- The Person-Centered Service Plan (PCSP) is developed by the DDA CRM/Social Service Specialist.
- Participants or contributors to this plan consist of:
  - o The individual,
  - o Their legal representative (if applicable),
  - o Providers, and
  - o Anyone else the individual would like to have participate or contribute (family, friends, etc.)
- The PCSP is completed at least once every 12 months. Planning for the PCSP begins 60 days in advance of the due date.
- For waiver participants in DCYF or Tribal dependency, DCYF or Tribal case plans will be shared with the DDA Case/Resource Manager;
- To the extent possible, DCYF or Tribal case workers will collaborate with DDA Case/Resource Managers to advocate, plan, consult, and deliver appropriate services for their common clients.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status.

The DDA Assessment is administered by the DDA CRM/Social Service Specialist and provides the internal assessment and contains the following modules which assess for participant needs, preferences, goals and health status:

1. The Support Assessment module contains:
   a. The Supports Intensity Scale Assessment (which includes the ICF/IID Level of Care for individuals age 16 and above);
   b. ICF/IID Level of Care Assessment for individual age 15 and under;
   c. Protective Supervision Scale;
   d. Caregiver Status Scale;
   e. Current Services Scale;
   f. SIS Behavior Scale; and
   g. SIS Medical Scale.

2. The Service Level Assessment module contains:
   a. Personal Care assessment tool;
   b. Employment Support Assessment tool; . The Employment Support Calculator that determines the number of hours of employment support was added to the Person-Centered Service Plan module in 2018 and is explained in WAC 388-828-9325.
   c. Sleep Assessment tool;
   d. Mental Health Assessment tool;
   e. Equipment tool;
   f. Medication Management tool;
   g. Medication tool;
   h. Seizure & allergies tool.

3. The Person-Centered Service Plan module contains:
   a. Service Summary tool;
   b. Support Needs tool;
   c. Finalize Plan tool;
   d. Environmental Plan tool;
   e. Equipment tool;
   f. DDA Referral tool;
   g. Plan review tool;
   h. Supported Living Rate Calculator;
   i. Foster Care Rate Assessment Calculator; and
   j. Individual and Family Support Calculator.

DDA also uses external assessments as a part of the PCSP process. Examples of external assessments include; nursing evaluations, PT/OT reports, psychological evaluations etc.

(c) How the participant is informed of the services that are available under the waiver.

Participants are informed of services available under the Waiver by:

1. The DDA HCBS Waiver Brochure and Waiver "Facts" which is enclosed with the letter confirming the PCSP meeting. The letter, Fact sheet and brochure are sent approximately 60 days prior to the Person-Centered Service Plan meeting. The DDA HCBS Waiver Brochure identifies waiver services.
2. During the course of the Person-Centered Service Plan meeting service options are discussed and described.
3. Washington Administrative Code (WAC) fully defines services available under the waiver and is made available upon request and via the DDA internet Website

(d) The plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.

Participant goals:

o There is a screen in the DDA assessment that allows for the documentation of participant goals.

Participant needs (including health care needs):

o Health and welfare needs are identified throughout the course of the assessment on multiple screens (please see section b above). Health and welfare needs are also identified by additional documentation submitted as part of the Person-Centered Service Plan process (i.e. medical reports).

Preferences:

o Participant preferences are identified as requests for service. This is documented in the body of the assessment as well as in the Person-Centered Service Plan.

(e) How Waiver and other services are coordinated:

Waiver and other services are coordinated by the CRM/Social Service Specialist Services identified to meet health and welfare needs are documented in the Person-Centered Service Plan.

Providers receive a copy of the Person-Centered Service Plan. This assists them to not only understand their role in the individual's life but also the supports others are giving.

The CRM/Social Service Specialist monitors the Person-Centered Service Plan to ensure health and welfare needs are being addressed as planned.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan.

The assessment identifies health and welfare needs.

o The identified needs populate the Person-Centered Service Plan.

- Business rules require each identified need to be addressed.

o When an identified need requires a Waiver funded service the CRM/Social Service Specialist is required to identify the specific provider and the service type that will address this need.

- The CRM/Social Service Specialist is required to provide sufficient documentation to allow the provider and the participant to know what the provider's responsibilities are.

o When a provider or service has not been identified the plan reflects the steps in place to identify either the service or the provider.

- When the service or provider is identified the PCSP is amended to reflect the updated plan.

The CRM/Social Service Specialist provides oversight and monitoring of the Person-Centered Service Plan.

(g) How and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Per WAC 388-845-3075:

o An individual may request a review of his/her/their Person-Centered Service Plan at any time by calling his/her/their case resource manager. If there is a significant change in conditions or circumstances, DDA must reassess the plan and amend the plan to reflect any significant changes. This reassessment does not affect the end date of the annual Person-Centered Service Plan.

Updates or amendments to the currently effective version of the Person-Centered Service Plan are tracked in the system.

o When a Service Level Assessment is moved from Pending to Current status, the Person-Centered Service Plan version attached to that assessment will lock (so a record is kept of the version that the client/representative has signed off on).

o Amendments do not change the Plan Effective date.

Each subsequent change to the Person-Centered Service Plan is saved. There are two types of amendments: those that require a new Service Level Assessment and those that do not. Examples would be:

Person-Centered Service Plan Amendment With New Assessment

o Change in status of client in key domain (behavior, medical, caregiver, ADL, etc.)

o Change of provider for residential service (the client physically moves)

o Change in a paid service

Person-Centered Service Plan Amendment Without New Assessment

o Change in demographic information only
o No change in status of client in key domain
o Change of provider for non-residential service
o Rate change only (e.g. roommate leaves so now only 3 clients vs. 4 clients in home)

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk Assessment and Mitigation occurs via the DDA Assessment and PCSP. The DDA assessment takes a comprehensive approach to assessing for risk and provides a mechanism for allowing the case resource manager and the individual to identify risks and develop a strategy to mitigate identified risk.

Health, welfare and safety needs are evaluated throughout the Support Assessment and Service Level Assessment modules in the DDA Assessment. They are then addressed in planning via formal referrals, authorized paid DDA Services and other documented support activities in the PCSP.

The DDA Assessment evaluates risk by assessing for the following:

- Unstable/potentially unstable diagnosis
- Caregiver training required
- Medication regimen affecting plan
- Immobility issues affecting plan
- Nutritional status affecting plan
- Current or potential skin problems
- Skin Observation Protocol
- Alcohol/Substance Abuse
- Depression
- Suicide
- Pain
- Mental Health
- Legal
- Environmental
- Financial
- Community Protection
  - o Community Protection criteria have been developed to identify clients not already on the Community Protection waiver, but who are exhibiting some extreme behaviors that could pose a public safety threat.

When risk areas are identified they populate a referral screen in the PCSP. The CRM/Social Service Specialist documents the plan/response to each item that populates the referral screen.

Emergency planning is an required component of the PCSP. Back up caregivers and emergency contacts are identified during the waiver participant's assessment and can be updated at any time. Back up and emergency plans are required in WAC for all residential providers. Arrangements for back-up plans vary from individual to individual. In some situations a back-up plan may be a family member. In others, a back up plan may include a paid provider stepping in to assure health and welfare needs are addressed during times of crisis.

WAC 388-828-1640
What are the mandatory panels in your DDA assessment?
After DDA has determined your client group, DDA determines the mandatory panels in your DDA assessment using the following tables. An "X" indicates that the panel is mandatory; an "O" indicates the panel is optional. If it is blank, the panel is not used.

(1) DDA "Assessment main" and client details information

	Client Group			
	Waiver and State	Other Medicaid	State Only	
DDA Assessment Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Assessment Main	X	X	X	X
Demographics	X	X	X	X
Overview	X	X	X	X
Addresses	X	X	X	X
Collateral Contacts	X	X	X	X
Financials	X	X	X	X

(2) Supports intensity scale assessment

	Client Group			
	Waiver and State	Other Medicaid	State Only	
DDA Assessment Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Home Living	X	X	X	X
Community Living	X	X	X	X
Lifelong Learning	X	X	X	X
Employment	X	X	X	X
Health & Safety	X	X	X	X
Social Activities	X	X	X	X
Protection & Advocacy	X	X	X	X

(3) Support assessment for children

	Client Group			
	Waiver and State	Other Medicaid	State Only	
DDA Assessment Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Activities of Daily Living	X	X	X	X
IADLs (Instrumental Activities of Daily Living)	X	X	X	X
Family Supports	X	X	X	X
Peer Relationships	X	X	X	X
Safety & Interactions	X	X	X	X

(4) Common support assessment panels

	Waiver and State	Other Medicaid	State Only	
DDA Assessment Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Medical Supports	X	X	X	X
Behavioral Supports	X	X	X	X
Protective Supervision	X	X	X	X
DDA Caregiver Status*	X	X	X	X
Programs and Services	X	X	X	X

*Information on the DDA Caregiver Status panel is not mandatory for clients receiving paid services in an AFH, BH, SL, GH, SOLA, or RHC.

(5) Service level assessment panels

	Waiver and State	Other Medicaid	State Only	
DDA Assessment Panel Name	No Paid Services	Only Residential	Paid Services	Paid Services
Environment	X	X	O	
Medical Main	O	X	O	
Medications	X	X	X	
Diagnosis	X	X	X	
Seizures	X	X	X	
Medication Management	X	X	X	
Treatments/programs	X	X	X	
ADH (Adult Day Health)	O	O	O	
Pain	X	X	X	
Indicators-Main	O	X	O	
Allergies	X	X	X	
Indicators/Hospital	X	X	X	
Foot	X	X	O	
Skin	X	X	O	
Skin Observation	O	O	O	
Vitals/Preventative	X	X	O	
Comments	O	O	O	
Communication-Main	O	X	O	

Speech/Hearing	O	X	O
Psych/Social	O	X	O
MMSE (Mini-Mental Status Exam)	O	X	O
Memory	O	X	O
Behavior	O	X	O
Depression	O	X	O
Suicide	O	O	O
Sleep	O	O	O
Relationships & Interests	O	O	O
Decision Making	O	X	O
Goals	X	O	O
Legal Issues	O	O	O
Alcohol	O	O	O
Substance Abuse	O	O	O
Tobacco	O	X	O
Mobility Main	O	X	O
Locomotion In Room	O	X	O
Locomotion Outside Room	O	X	O
Walk in Room	O	X	O
Bed Mobility	O	X	O
Transfers	O	X	O
Falls	O	O	O
Toileting-Main	O	X	O
Bladder/Bowel	O	X	O
Toilet Use	O	X	O
Eating-Main	O	X	O
Nutritional/Oral	O	X	O
Eating	O	X	O
Meal Preparation	O	X	O
Hygiene-Main	O	X	O
Bathing	O	X	O
Dressing	O	X	O
Personal Hygiene	O	X	O
Household Tasks	O	X	O
Transportation	O	X	O
Essential Shopping	O	X	O
Wood Supply	O	X	O
Housework	O	X	O
Finances	O	O	O
Pet Care	O	O	O
Functional Status	O	O	O
Employment Support*	X*	X*	X*
Mental Health	X	X	X
DDA Sleep*	X*	O	O

*Indicates that:

(a) The "Employment Support" panel is mandatory only for clients age twenty-one and older who are on or being considered for one of the county services listed in WAC 388-828-1440(2).

(b) The "DDA Sleep" panel is mandatory only for clients who are age eighteen or older and who are receiving:

(i) DDA HCBS Core or Community Protection waiver services; or

(ii) State-Only residential services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants are given free choice of all qualified/approved providers of each service approved in his/her/their plan. During the course of the PCSP process the participant is advised she/he/they have a choice of providers. The assessment meeting includes an Assessment Wrap-up checklist that the client and/or her/his/their representative signs. One of the items on the checklist is a statement verifying that the individual understands that she/he/they has a choice of and can change provider(s). Also, at the time of the annual person-centered service plan (PCSP) update, participants have an opportunity to select alternative providers. Waiver participants can also select alternative providers at any time by requesting an update of their PCSP.

The Case Resource Manager (CRM)/Social Service Specialist will provide information to access appropriate referral registries, contract database list and/or websites to facilitate access to provider lists and assist with the contracting process.

In-home Respite:
All client's can contact the Home Care Referral Registry to access an individual respite provider. DDA provides client's the contact information to the Referral registry or information can be accessed from the internet Home Care Referral Registry website @http://www.hcrr.wa.gov/

- The Home Care Referral Registry is maintained by the Home Care Quality Authority. The Registry provides information about available Individual providers (IPs) in a geographic areas who are interested in being interviewed for potential hire.
- DDA provides lists of agencies contracted to provide in-home services and families choosing an agency, work with agency staff to select individuals to work in their homes.

- Other Provider types
  - o Lists of provider of specific services can be generated out of the Agency Contracts Data Base (ACD) maintained by DSHS. Provider recruitment is ongoing and contract referrals are accepted on a continual basis.
  - o The ALTSA Internet page maintains provider lists for Adult Family Home and Adult Residential Care Facilities.
  - o The DDA Internet page maintains a supported living provider locator.
  - o Contractors for Environmental Adaptations are listed by Labor & Industries, along with information about their licenses and any actions taken against them. Families may choose from this broad list of contractors and refer them to DDA for contracting. DDA also maintains a list of contractors.
  - o ProviderOne maintains an online search engine open to the public for providers of therapy, counseling, and other services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The Developmental Disabilities Administration (DDA) operates a number of quality assurance (QA) processes that ensures that person-centered individual service plans meet the needs of waiver participants. At the end of each QA review cycle, a final report is generated which includes detailed data on a statewide level. These results are analyzed and incorporated into a statewide quality improvement plan. The State Medicaid Agency receives annual QA review reports and meets with the operating agency at the conclusion of the QA cycle to review results and provide input into the quality improvement plan. The quality improvement plan is then reviewed and approved for implementation by DDA executive management. This is part of a total Quality Improvement Strategy (QIS), which includes surveys, file reviews, performance measures, ternary evaluations of performance measures, and staff training.

More detail on QA processes as they relate to the individual support plan is provided below.

The mechanism for ongoing oversight of waiver operation by the Single State Medicaid Agency is the Medicaid Agency Waiver Management Committee, which includes representatives from administrations and divisions within the operating agency, Home and Community Services and Residential Care Services, which are divisions within the operating agency, as well as the Developmental Disabilities Administration (DDA) and the Behavioral Health Administration (BHA). The Committee meets at least quarterly to review all functions delegated to the operating agency, current quality assurance activity, pending waiver activity (e.g. amendments, renewals, etc.), potential waiver policy and rule changes and quality improvement activities.

The Developmental Disabilities Administration is an administration within the Department of Social and Health Services (DSHS), which is the operating agency. The individual Case Resource Manager/Social Service Specialist is an employee of DDA. DDA determines client eligibility and requires the use of the administration's electronic assessment and service planning tool. DDA Case Resource Managers/Social Service Specialists directly authorize all initial service plans and supervisors conduct quality assurance activities on service plans. DDA has direct electronic access to all service plans.

DDA has a comprehensive monitoring process to oversee the planning process and the person-centered service plan (PCSP). In addition, DDA participates in the National Core Indicators Survey and initiates a PCSP survey. Data is gathered and analyzed and necessary steps are taken to correct areas of concern.

DDA monitoring process:
The DDA Quality Compliance Coordinator(QCC) Team completes an annual review of randomly selected files across all waivers. The list for the QCC team review is generated to produce a random sample with a 95% confidence level with a margin of error a +/- 5. Included in the review are items concerning the person-centered planning process and content of the PCSP.

The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by the QCC Team. Findings are analyzed by DDA management. Based on the analysis necessary steps are taken, such as:

- Annual Waiver Training curriculum is developed in part to address review findings.
- Policy clarifications are issued.
- Personnel issues are identified.
- The format of and instructions on forms are modified.
- Waiver WAC is revised to clarify rule.
- Regional processes are updated.

The National Core Indicators Survey:
Washington State's Developmental Disabilities Administration (DDA) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the administration to compare it's performance to service systems in other states and within our state from year to year.

There are currently 46 performance and outcome indicators to be assessed covering the following domains:

- Consumer Outcomes
- System Performance
- Health, Welfare, & Rights
- Service Delivery System Strength & Stability

In addition, DDA has added some waiver specific questions to assist with assuring PCSPs are implemented as written and

that health and welfare needs are being addressed. Findings are analyzed by DDA management and shared with stakeholders. The Washington State Developmental Disabilities Council (DDC) participates in the survey process by analyzing results.

An Assessment meeting wrap-up form is given to each waiver participant at the conclusion of the PCSP planning meeting. This form gives participants an opportunity to respond to a series of questions about the PCSP process.

A PCSP Meeting survey is mailed to waiver participants within one month of the PCSP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the PCSP process. The survey is mailed from Central Office based on a random sample representative of all waivers with a 95% confidence level with a margin of error of +/-5%. Information collected is analyzed annually by the Medicaid Agency Waiver Management Committee.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☒ **Operating agency**
- ☒ **Case manager**
- ☒ **Other**

Specify:

Copies of the signed PCSP are kept in the client files which are maintained in the DDA regional offices. Electronic copies of the PCSP are maintained on the CARE platform.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The regional DDA Case Resource Manager (CRM) or Social Service Specialist (SSS)provides the primary oversight and monitoring of the Person-Centered Service Plan. The State notes that the frequency of monitoring by Case/Resource Managers or Social Service Specialists is determined in part by risk factors identified in the annual assessment to assure health and welfare. The DDA CRM or Social Service Specialist authorizes the Waiver Services identified as necessary to meet health and welfare needs in the Person-Centered Service Plan. The DDA CRM or Social Service Specialist monitors service provision no less than two times per year by at least one face to face in-person or virtual client visit and an additional contact with the waiver participant/legal representative which can be completed by telephone, e-mail or face to face. If a waiver participant chooses to have their annual assessment completed virtually, the Case/Resource Manager is mandated to schedule an on-site visit to determine the health and safety of the waiver participant in their residential setting. The Case/Resource Manager may monitor service provision in-person or virtually at the discretion of the Case/Resource Manager consistent with known risk factors. Continuous monitoring also occurs by contacting providers; reviewing progress reports submitted by providers and reviewing additional assessments (e.g. IEPs, psychological evaluations, Occupational Therapy evaluations etc.). If the DDA CRM or Social Service Specialist finds that the Person-Centered Service Plan is not meeting the individual's needs the Person-Centered Service Plan will be revised/amended. All monitoring is documented in either the Service Episode Record section of the electronic DDA Assessment or on the Monitoring tab of the Waiver Screen in CARE.

Signatures by participants on Person-Centered Service Plans may be manual (pen on paper) or electronic signatures. Washington State law (RCW Chapter 1.80 Uniform Electronic Transactions Act) authorized the use of electronic signatures when both parties to the transaction agree. The State proposes to collect electronic signatures using the following technologies: 1) signatures documented using Adobe E-Signature which is stored in DDA’s Records Management Tool, DDA’s electronic document repository and 2) voice signatures using Amazon Connect where the Case/Resource Manager calls the waiver participant on a recorded line, confirming their identity using two identifiers and documenting their approval in the recording and in a signature form in CARE Web. Case/Resource Managers document on a signature page that DDA received a voice signature, and this is uploaded to the Records Management Tool. Electronic communication with waiver participants for signatures is secured with access via a PIN generated by CARE Web and given to the waiver participant by the Case/Resource Manager. All signature options are documented on the signature page of the Person-Centered Service Plan in CARE Web and voice signatures recordings are stored by Amazon Connect through a contract with DDA.

At the time of the annual review, the CRM/Social Service Specialist is required to review the effectiveness of last year's plan with the individual and/or their legal representative. This review is a required step before the DDA Assessment will allow the CRM to create a new assessment. All plans are expected to address emergency preparedness such as: back-up caregivers, evacuation plans, what to do in case of natural disaster etc. The plan review process provides an opportunity to review the effectiveness of these plans.

In addition to DDA CRM/Social Service Specialist monitoring activities, the following occur:

- A sample of waiver case files is reviewed by Quality Compliance Coordinators.
  - o Quality Compliance Coordinators review annually a statewide random sample of waiver files.
  - o Waiver case files are reviewed for the following evidence:
    - The PCSP was completed within 12 months.
    - The individual was given a choice between waiver services and institutional care.
    - The individual meets the ICF/IID level of care standard.
    - The individual meets disability criteria.
    - The individual is financially eligible.
    - Services have been authorized in accordance with the person-centered service plan.
    - Waiver services or appropriate monitoring activities are occurring every month.
    - All authorized services are reflected in the plan.
    - All providers are qualified to provide the services for which they are authorized.
    - The individual was given a choice of qualified providers.
    - Appeal rights and procedures have been explained.

National Core Indicators Survey (NCI) face to face interviews:
Washington State's Developmental Disabilities Administration (DDA) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the administration to compare it's performance to service systems in other states and within our state from year to year.

Currently 46 performance and outcome indicators are assessed that cover the following domains:

- Consumer Outcomes
- System Performance
- Health, Welfare, & Rights
- Service Delivery System Strength & Stability

In addition, DDA has added waiver-specific questions to assist with assuring PCSPs are implemented as written and that health and welfare needs are being addressed.

Examples of waiver specific questions:

- If you need to change your child's services, do you know what to do?
- Do the services and supports offered on your Person-Centered Service Plan meet your child's and family's needs?
- Did you (did the waiver participant) receive information at your (his/her/their) person-centered service plan meeting about the services and supports that are available under the (his/her/their) waiver?

Findings are analyzed by DDA management and shared with stakeholders. The Washington State Developmental Disabilities Council (DDC) participates in the survey process by analyzing results.

Assessment Meeting Wrap-up and PCSP Survey:
An Assessment Meeting Wrap-up is given to each waiver participant at the conclusion of the PCSP planning meeting. The Wrap-up survey gives participants an opportunity to respond to a series of questions about the PCSP process. And after the assessment is finalized, Central Office sends an PCSP survey to a statistically-valid random sample of waiver participant with a return envelope to allow for an anonymous submission to Central Office.

Questions on the PCSP survey:

- Did you get to choose who came to your meeting?
- Did your Case Resource Manager discuss any concerns you have with your current services?
- Were your concerns addressed in your new person-centered service plan?
- Did you receive information about what services are available in your waiver to meet your assessed needs?
- Were you given a choice of services that are available in your waiver to meet your identified needs?
- Were you given a choice of service providers?
- Were your personal goals discussed in developing your plan?
- Do you feel like your health concerns are addressed to your satisfaction?
- Do you feel like your safety concerns are addressed adequately?
- Did you receive information regarding planning for emergencies, such as an earthquake or other natural disaster?
- Do you know who to contact if your needs change before the next assessment?
- Do you know you have a right to appeal decisions made by DDA?
- Did your case resource manager explain how to use your Planned Action Notice (PAN) to appeal a service decision in your support plan if you disagree with that decision?

Residential Care Services (RCS) certifies DDA residential providers and licenses adult family homes and boarding (group)homes, all of which are qualified providers of respite services.

- o These providers are evaluated at a minimum of every two years.
- o A component of the RCS evaluation process is a review of the PCSP to ensure the agency is implementing the plan as written.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participantsâ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
D.a.7 The number and percent of annual waiver PCSPs where waiver participants chose the people who participated in their assessment and person-centered planning meeting. N = Number of annual waiver PCSPs where waiver participants chose the people who participated in their assessment and person-centered planning meeting. D = All annual waiver PCSPs created.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CARE system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

D.a.5. The number and percent of waiver PCSPs which include emergency planning. N = Number of waiver PCSPs which include emergency planning. D = All waiver PCSPs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Assessment Reporting and Evaluation (CARE) system

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.3. The number and percent of waiver participants' PCSPs with monthly waiver service provision or monitoring by the case resource manager during a break in services. N = Number of waiver participants' PCSPs with monthly waiver service provision or monitoring by the case resource manager during a break in service. D = All waiver participants' PCSPs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error

☒ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.1. # & % of waiver participants' PCSPs that address waiver participants' assessed health and welfare needs through the provision of waiver services or other means. N = # of waiver participants' PCSPs that address waiver participants' assessed health and welfare needs through the provision of waiver services or other means. D = All waiver participants' PCSPs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Assessment Reporting and Evaluation (CARE) system.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.6. Number & percent of waiver participants reporting through NCI surveys that they and people they invited are involved in the creation of their person-centered service plan (PCSP) N = Number of waiver participants reporting through NCI surveys that they and people they invited are involved in the creation of their PCSP D = All waiver participants responding to NCI survey reviewed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
NCI Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.4. Number and percent of waiver recipients' PCSPs with critical indicators triggered in the assessments that were addressed in their PCSPs. N = Number of waiver recipients' PCSPs with critical indicators triggered in the assessments that were addressed in their PCSPs. D = All waiver recipients' PCSPs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.2. The number and percent of Person-Centered Service Plans (PCSPs) conducted for waiver participants with identified personal goals addressed in their PCSPs. N = Number of PCSPs conducted for waiver participants with identified personal goals addressed in their PCSPs. D = All waiver participants' PCSPs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Assessment Reporting and Evaluation (CARE) system.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participantâs needs.***

Performance Measures

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

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

Performance Measure:
D.c.3. # & % of waiver participants who experienced a significant change in needs who received a required significant change assessment & whose PCSP was updated.
N = Number of waiver participants who experienced a significant change in needs who received a required significant change assessment & whose PCSP was updated.
D = All waiver participants who experienced a significant change in needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Assessment Reporting and Evaluation (CARE) system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.c.2. # & % of waiver participants & family members responding to PCSP Meeting Survey (PCSPMS) who report knowing what to do if their needs change before next annual PCSP meeting N = # of wvr parts & family members responding to PCSPMS who report knowing what to do if their needs change before next annual PCSP mtg D = All wvr participants & family members responding to PCSPMS reviewed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☒ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☒ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.c.1. The number and percent of annual waiver PCSPs that are completed before the end of the twelfth month following the initial PCSP or the last annual PCSP. N = The number of annual waiver PCSPs that are completed before the end of the twelfth month following the initial PCSP or the last annual PCSP. D = All waiver PCSPs due for annual review that were reviewed.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
D.d.4. Number & percent of waiver participants' PCSPs whose PCSP services are all authorized in ProviderOne screens in CARE. N = Number of waiver participants' PCSPs whose PCSP services are all authorized in ProviderOne screens in CARE. D = All waiver participants' PCSPs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.d.3. # & % of waiver PCSPs with service authorizations in place for waiver funded services that occurred that should have occurred in last 3 months. N = # of wvr PCSPs with service authorizations in place for wvr funded services that occurred that should have occurred in last 3 months. D = All wvr PCSPs that should have included a service authorization in last 3 months that were reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.d.2. Number & percent of waiver PCSPs with services that are delivered within 90 days of the PCSP effective date or as specified in the PCSP. N = Number of waiver PCSPs with services that are delivered within 90 days of the PCSP effective date or as specified in the PCSP. D = All waiver PCSP reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.d.5. The number and percent of waiver participants who report receiving services in accordance with the type, scope, amount, duration and frequency specified in their PCSP. N = Number of waiver participants who report receiving services in accordance with the type, scope, amount, duration and frequency specified in their PCSP. D = All waiver participants surveyed that were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Service Verification survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.d.1. Number & percent of waiver PCSPs with services that are delivered in accordance with the type, scope, amount, duration, and frequency as specified in the PCSP. N = Number of waiver PCSPs with services that are delivered in accordance with the type, scope, amount, duration, and frequency as specified in the PCSP. D = All waiver PCSPs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Quality Compliance Coordinator (QCC) Team within DDA.	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
D.e.1. # & % of waiver participant records that contain annual assessment meeting wrap-up that verifies that waiver participant had a choice between/among waiver services & providers. N = # of wvr participant records that contain annual assessment meeting wrap-up that verifies that wvr participant had a choice between/among waiver services & providers. D = All waiver part records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CARE System data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

QIPs for Performance Measures D.d.2, D.d.3 and D.e.1 are located at Main B. Optional

PM D.a.1, D.a.2, D.a.5, D.a.7 and D.c.3 are 100% annual reviews based on data from the CARE system that is analyzed by the Waiver Team and reviewed by DDA management. PM D.d.5 is an annual representative sample drawn from the Medicaid Service Verification Survey that is analyzed by the Waiver Team and reviewed by DDA management.
D.a.3; D.a.4; D.c.1; D.d.1; D.d.2; D.d.3; D.d.4; D.e.1: The QCC Team completes an annual audit of randomly selected files across all DDA waivers. The list for the QCC Team audit is generated to produce a random sample representative of all waivers with a 95% confidence level with a +/-5% margin of error. The findings from these reviews are collected in a database. All findings are expected to be corrected within 90 days. Corrections are monitored by QCC Team members.
A valid sample is produced for the QCC audit. The remaining file review is strictly an additional measure to assist with ongoing quality assurance.
The audit protocol includes (among others) the following questions with a target of 100% compliance:
• Have all identified waiver funded services been provided within 90 days of the annual PCSP effective date?
• Is there a ProviderOne or Individual ProviderOne authorization for all Waiver funded services identified in the current PCSP that should have occurred in the three (3) months prior to this review?
• Are all the current services authorized in ProviderOne or Individual ProviderOne Screen identified in the PCSP?
(Authorizations are audited as a proxy for claims data. The ProviderOne and Individual ProviderOne electronically prevents a provider from claiming payment for an amount and rate higher than what is authorized.)
• Are the authorized service amounts equal or less than the amounts identified in the PCSP?
• Is the effective date of this year's annual PCSP no later than the last day of the 12th month of the previous annual PCSP effective date?
• Is there evidence that the Wrap-Up discussion occurred at the DDA annual or initial assessment?
• Is there a signed Voluntary Participation statement from the annual or initial assessment in the client file?
D.a.2: The DDA assessment allows for entry and addressing of personal goals. An annual report is generated at DDA Central Office and annually reviewed by DDA management to identify assessments with one or more personal goals to verify personal goals are acknowledged and addressed. Data are available in a computer-based system which provide 100% analysis of individual results.
D.a.5: An annual report is created and reviewed by DDA management to verify that emergency plans are documented in waiver participants' PCSPs.
D.a.6: DDA management annually compares data on response rates to NCI questions and responses from waiver year to waiver year. DDA constructs pie charts for questions and analyzes the outcome of the survey with the HCA Medicaid Agency Waiver Management Committee and stakeholders. DDA uses this information to assist with the development of the Waiver training curriculum as well as to develop needed policy changes.
D.c.1: Monthly reports are prepared and reviewed by DDA management for a review of the progress toward achieving 100% timely assessments of need. The data is analyzed by comparing the actual number of assessments completed on time to the regional monthly targets and to the assessments that were due. Regional Waiver Specialists review Assessment Activity Reports on a monthly basis and send information to case resource managers for follow-up to promote timeliness of assessments.
D.c.2: Person-Centered Service Plan Meeting Survey: A PCSP Meeting survey is mailed to waiver participants within one month of the PCSP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the PCSP process. The survey is mailed from DDA Central Office based on a random sample representative of all waivers with a 95% confidence level and a +/-5% margin of error. Information collected is analyzed and reviewed by DDA management annually and by the HCA Medicaid Agency Waiver Management Committee.
Questions in the Person-Centered Service Plan Meeting Survey include:
• Did you get to choose who came to your meeting?
• Did you get to choose the time and place of your meeting?
• Were you given the opportunity to lead your meeting?
• Were your personal goals discussed in developing your plan?
• Were you given a choice of services?
• Did you choose where and how the services will be provided?
• Did your case resource manager review last year's plan and ask what supports you want to continue and what should change?

• Were any concerns you may have had addressed in your new plan?
• Did you receive information about resources and services available to meet your goals?
• Were you given a choice of providers?
• Were plans made to meet any health and safety concerns you may have had?
• Did you receive information regarding planning for emergencies, such as an earthquake or other natural disaster?
• Do you know who to contact if your needs change before your next assessment?

b. Methods for Remediation/Fixing Individual Problems

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

All results are reviewed by program managers on the QCC Team and by senior DDA management at least annually. Individual client issues discovered during annual reviews are corrected by CRMs and with oversight by the QCC Team. Systemic issues discovered in the course of annual reviews are brought by the QCC Team to senior DDA management for necessary policy, procedure or other corrective actions. In addition, the Washington State Developmental Disabilities Council (DDC) also participates in an annual review of QIS data analysis and remediation.

PM D.a.1, D.a.7 and D.c.3 are 100% reviews based on data from the CARE system. PM D.d.5 is a representative sample drawn from the Medicaid Service Verification Survey.
D.a.1, D.a.2, D.a.5, D.a.7 & D.c.3 – CARE data findings are analyzed by management, and based on the analysis necessary steps are taken to increase compliance. D.d.5 – Medicaid Service Verification Survey results are analyzed by management, and based on the analysis necessary steps are taken to increase compliance.
D.a.3; D.a.4; D.c.1; D.d.1; D.d.2; D.d.3; D.d.4; D.e.1: Waiver File Reviews (Annual QCC audit):
Findings from QCC Team and Supervisor file reviews are analyzed by management, and based on the analysis necessary steps are taken to increase compliance. For example:
* Annual Waiver Training curriculum is developed in part to address audit findings.
* Policy clarifications occur as a result of audit findings.
* Analyses of findings assist regions to recognize personnel issues.
* Analysis of audit finding may impact format and instructions on forms.
* Analysis of findings has led to revision in Waiver WAC to clarify rule.
* Analysis of findings has led regions to revise regional processes.

D.a.6: The National Core Indicators Survey:
Washington State's Developmental Disabilities Administration (DDA) participates in a national study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the administration to compare its performance to service systems in other states and within our state from year to year.
There are currently 46 performance and outcome indicators to be assessed covering the following domains:
* Consumer Outcomes
* System Performance
* Health, Welfare, & Rights
* Service Delivery System Strength & Stability
In addition, DDA has added some waiver specific questions to assist with assuring PCSPs are implemented as written and that health and welfare needs are being addressed. Findings are analyzed by management and shared with stakeholders. The Washington State Developmental Disabilities Council (DDC) participates in the survey process both in visiting clients and analyzing results.

D.c.2: Person-Centered Service Plan Meeting Survey: DDA compares data on response rates to the Person-Centered Service Plan Meeting Survey and responses from waiver year to waiver year. DDA constructs pie charts for questions and analyzes the outcome of the survey with the HCA Medicaid Agency Waiver Management Committee and stakeholders. DDA uses this information to assist with the development of the Waiver training curriculum as well as to develop needed policy changes.
* Annual Waiver Training curriculum is developed in part to address audit findings.
* Policy clarifications occur as a result of audit findings.
* Analysis of audit finding may impact format and instructions on forms.
D.d.5 State utilizes Medicaid Service Verification Survey as an additional tool to identify and correct issues with the waiver service delivery system.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☒ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Waiver clients have rights under Medicaid law, state law (RCW) and state rules (WAC) to appeal any decision of DDA affecting eligibility, service, or choice of provider.

During the waiver application process, an individual receives the DDA HCBS Waiver Brochure (DSHS #22-605), which explains their administrative hearing rights. The CRM/Social Service Specialist discusses administrative hearing rights at the time of the initial and annual PCSP meeting, and Planned Action Notices (PAN) are attached to the PCSP when it is sent to the individual and their designee (the individual who has been designated to assist the client with understanding and exercising their administrative hearing rights) for signature. The PANs describe the service decisions made by DDA and contain information on how to request an administrative hearing to appeal DDA's decision.

When DDA makes a decision affecting eligibility, level of service or denial or termination of provider, a Planned Action Notice (PAN) must be sent within 5 working days of the decision. The notice is sent to the waiver participant and her/his/their designee. The PAN provides the effective date of the action, the reason and applicable WAC, appeal rights, and time lines for filing appeals. Individuals have up to 90 days to appeal a department decision. If an individual wishes to maintain services during the appeal process, they must ask for an administrative hearing within the ten-day notice period.

A client or representative may request an administrative hearing orally or in writing. Client appeals are heard and decided by Administrative Law Judges (ALJs) through an administrative hearing. Attorney representation is not required but is allowed. The client or their representative may present the client's case or have an attorney present the case. DSHS employees may not represent the client at an administrative hearing.

PANs are contained electronically in the DDA Assessment on the CARE platform. If the PAN was modified then a copy of the modified PAN is maintained in the waiver participant's file. Service Episode Records (SERs) document when a PAN was sent. SERs are contained electronically in the DDA Assessment on the CARE platform.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Development Disabilities Administration (DDA) of the Department of Social and Health Services (DSHS) operates the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDA provides participants with administrative hearing rights and a complaints/grievance process. The Complaints/Grievance process is not a pre-requisite to an administrative hearing; rather this policy provides participants with an opportunity to address those issues that are not dealt with through the administrative hearing process. DDA policy 5.03 (Client Complaint/Grievances) clearly delineates those issues that may be addressed in this manner and those issues that should be addressed through processes such as the administrative hearing process. Participants are informed of both processes via brochures, DVDs, WAC, policy and their case resource manager.

DDA policy 5.03 provides waiver participants an opportunity to address problems outside the scope of the adminitrative hearing process. DDA has also collaborated with the Developmental Disabilities Council to produce a video to assist individuals and their representatives understand how to work with the department to resolve complaints/grievances.

POLICY

A. DDA staff will strive to address grievances/complaints at the lowest level possible. Complaints can be received and addressed at any level of the organization. However, the complaint will be referred back to the Case Resource Manager/Social Service Specialist (CRM/SSS) for action unless the complainant specifically requests it not be.

B. Legal authorization from the client or her/his personal representative is required to share information with persons outside of DSHS unless otherwise authorized by law. Authorization from the client is not required when responding to correspondence assignments or inquiries from the Governor's Office as part of administration of DSHS programs.

C. Communication to complainants will be made in their primary language if needed.

D. DDA maintains a complaint tracking database to log and track complaints as specified in the Procedures section of this policy. DDA also tracks complaints in service episode records (SERs) in the CARE system.

PROCEDURES

A. The following procedures describe the handling of waiver participant complaints at four levels:

1. Case Resource Manager/Social Service Specialist Level;
2. Supervisor Level;
3. Regional Administrator (RA) Level; and
4. Central Office Level

B. Complaints concerning services in the DDA Residential Habilitation Centers (RHCs) and State Operated Living Alternatives (SOLA) will be directed to the Regional Administrator in the respective region.

C. Case Resource Manager(CRM)/Social Service Specialist (SSS) Level

1. CRMs and SSSs solve problems and resolve complaints as a daily part of their regular case management activities. This activity is documented in the client record as appropriate in SER's. The Complaint SER's code is used to identify complaints and any resolution to the complaints.

2. If the complainant does not feel that the complaint or problem has been resolved, and she/he/they wants to have the complaint reviewed by a supervisor, the CRM/SSS will give her/his/their supervisor's name and telephone number to the complainant.

D. Supervisor Level

1. Upon receipt of an unresolved complaint at the CRM/SSS level, the supervisor has ten (10) working days to resolve the issue. If the response will take longer than 10 working days, the supervisor makes an interim contact with the complainant and provides a reasonable estimated date of response.

2. If resolution is reached, the supervisor documents the outcome in the client record.

3. If the complainant still does not feel that the complaint/problem has been resolved, and she/he/they wants to have the complaint reviewed by the Regional Administrator (RA), the supervisor gives the RA's name and telephone number to the complainant. The supervisor also enters the complaint information in the automated DDA Complaint Tracking (CT) database.

E. Regional Administrator Level

1. Upon receipt of an unresolved complaint, the RA assigns a staff to investigate and resolve the issue within 10 working days. If the response will take longer than 10 working days, the RA or designee will make an interim contact with the complainant and give a reasonable estimated date of response.

2. If resolution is achieved, the assigned Regional staff:

a. Documents the outcome in the CT database and the client record; and

b. Notifies the complainant and all parties involved and document the notification in the client record.

3. If the matter is not resolved, and the complainant wants a review by DDA Central Office, the RA or designee documents the outcome in the CT database and gives the name and telephone number of the Chief, Office of Quality Assurance (OQA) to the complainant. The RA also notifies the OQA Chief by phone or email of the potential contact.

F. Central Office Level

1. Upon receipt of an unresolved complaint, the OQA Chief or designee ensures the complaint has been entered in the database and has ten (10) working days to investigate and resolve the issue.
If the response will take longer than ten (10) days, the OQA Chief makes an interim contact with the complainant and give a reasonable estimated date of response.

2. The OQA Chief documents the outcome in the CT database and notifies the complainant and all parties involved. The OQA Chief sends a written summary to the Region for inclusion in the client record.

G. Complaint Tracking (CT) Database

1. Entries in the CT database must include:
a. Date the complaint was received;
b. Name and phone number of person receiving the complaint;
c. Complainant name, contact number, and relationship to client;
d. Client name and identification number;
e. The specific complaint;
f. Who the complaint was assigned to;
g. Due date; and
h. Outcome.

2. The OQA reviews complaints entered in the CT database during its monitoring review cycle. Regional Quality Assurance Managers conduct periodic regional reviews of complaints and their status.

The following types of complaints are outside the scope of this policy as they are addressed through separate processes:

1. Allegations of abuse, neglect, exploitation, abandonment, financial exploitation of a child or vulnerable adult. These are directed immediately to Adult Protective Services (APS), the Complaint Resolution Unit (CRU), or Child Protective Services (CPS), as appropriate.

2. Client disputes about services that have been denied, reduced, suspended, or terminated. These are resolved through the administrative hearing procedure.

3. Client disputes about services that have been requested or authorized through an exception to rule (ETR) that have been denied, reduced, or terminated.

4. Complaints received from DSHS Constituent Services. These are handled according to the requirements of DSHS Administrative Policy 8.11, Complaint Resolution and Response Standards.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Several state laws require Department of Social and Health Services (DSHS) employees, volunteers, and contractors to report suspected abandonment, abuse, neglect, exploitation, and financial exploitation of children and vulnerable adults:
• Chapter 26.44 RCW mandates the reporting of any suspected abuse or neglect of a child to either DSHS or law enforcement.
• Chapter 74.34 RCW mandates an immediate report to DSHS of suspected abuse, neglect, abandonment, or financial exploitation of a vulnerable adult. When there is suspected sexual or physical assault of a vulnerable adult, it must be reported to DSHS and to law enforcement.
• RCW 70.124.030 mandates the reporting of suspected abuse or neglect of state hospital patients.
Chapter 74.34 RCW divides reporters into two types: mandated and permissive. Per RCW 74.34.020, "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW (Regulation of health professions-Uniform disciplinary act).

“Permissive reporter” means any person, including but not limited to, an employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults.
Under state law, volunteers at a facility or program providing services to vulnerable adults fall into the permissive category. However, in order for contractors, volunteers, interns, and work study students to work in regional Field Services offices, Residential Habilitation Centers (RHC), and State Operated Living Alternatives (SOLA), they must agree to follow mandatory reporting requirements
The Developmental Disabilities Administration (DDA) requires all contracted residential providers to report a broader scope of serious and emergent incidents to the Administration per DDA Policy 6.12 (Residential Reporting Requirements). Serious and emergent incidents are reported to DDA via fax, telephone and e-mail.
More detail is provided below and is broken out by incidents concerning children, incidents concerning adults, and the incidents that must be reported and entered into DDA’s Electronic Incident Reporting System.

Children
The State requires that “abuse” and “neglect” be reported for review and follow-up action by an appropriate authority. Per RCW 26.44.020(1): "Abuse or neglect" means sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, excluding conduct permitted under RCW 9A.16.100 (Use of force on children-Policy-Actions presumed unreasonable); or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is a child who has been subjected to child abuse or neglect as defined in this section.
Who must report instances of suspected child abuse and neglect and the timelines associated with reporting are contained in RCW 26.44.030 (Reports-Duty and authority to make-Duty of receiving agency....).
(1)(a) When any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombuds or any volunteer in the ombuds's office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040 (Reports-Oral, written-Contents).
(b) When any person, in his or her official supervisory capacity with a nonprofit or for-profit organization, has reasonable cause to believe that a child has suffered abuse or neglect caused by a person over whom he or she regularly exercises supervisory authority, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency, provided that the person alleged to have caused the abuse or neglect is employed by, contracted by, or volunteers with the organization and coaches, trains, educates, or counsels a child or children or regularly has unsupervised access to a child or children as part of the employment, contract, or voluntary service. No one shall be required to report under this section when he or she obtains the information solely as a result of a privileged communication as provided in RCW 5.60.060 (Witnesses-Competency-Who is disqualified-Privileged communications).
Nothing in this subsection (1)(b) shall limit a person's duty to report under (a) of this subsection.
(c) The reporting requirement also applies to department of corrections personnel who, in the course of their employment, observe offenders or the children with whom the offenders are in contact. If, as a result of observations or information received in the course of his or her employment, any department of corrections personnel has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report the incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040.

(d) The reporting requirement shall also apply to any adult who has reasonable cause to believe that a child who resides with them, has suffered severe abuse, and is able or capable of making a report. For the purposes of this subsection, "severe abuse" means any of the following: Any single act of abuse that causes physical trauma of sufficient severity that, if left untreated, could cause death; any single act of sexual abuse that causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness.

(e) The reporting requirement also applies to guardians ad litem, including court-appointed special advocates, appointed under Titles 11, 13, and 26 RCW, who in the course of their representation of children in these actions have reasonable cause to believe a child has been abused or neglected.

(f) The reporting requirement in (a) of this subsection also applies to administrative and academic or athletic department employees, including student employees, of institutions of higher education, as defined in RCW 28B.10.016 (Colleges and universities generally-Definitions), and of private institutions of higher education.

(g) The report must be made at the first opportunity, but in no case longer than forty-eight hours after there is reasonable cause to believe that the child has suffered abuse or neglect. The report must include the identity of the accused if known.

(2) The reporting requirement of subsection (1) of this section does not apply to the discovery of abuse or neglect that occurred during childhood if it is discovered after the child has become an adult. However, if there is reasonable cause to believe other children are or may be at risk of abuse or neglect by the accused, the reporting requirement of subsection (1) of this section does apply.

(3) Any other person who has reasonable cause to believe that a child has suffered abuse or neglect may report such incident to the proper law enforcement agency or to the department of social and health services as provided in RCW 26.44.040.

(4) The department, upon receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means or who has been subjected to alleged sexual abuse, shall report such incident to the proper law enforcement agency. In emergency cases, where the child's welfare is endangered, the department shall notify the proper law enforcement agency within twenty-four hours after a report is received by the department. In all other cases, the department shall notify the law enforcement agency within seventy-two hours after a report is received by the department. If the department makes an oral report, a written report must also be made to the proper law enforcement agency within five days thereafter.

(5) Any law enforcement agency receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means, or who has been subjected to alleged sexual abuse, shall report such incident in writing as provided in RCW 26.44.040 to the proper county prosecutor or city attorney for appropriate action whenever the law enforcement agency's investigation reveals that a crime may have been committed. The law enforcement agency shall also notify the department of all reports received and the law enforcement agency's disposition of them. In emergency cases, where the child's welfare is endangered, the law enforcement agency shall notify the department within twenty-four hours. In all other cases, the law enforcement agency shall notify the department within seventy-two hours after a report is received by the law enforcement agency.

(6) Any county prosecutor or city attorney receiving a report under subsection (5) of this section shall notify the victim, any persons the victim requests, and the local office of the department, of the decision to charge or decline to charge a crime, within five days of making the decision.

Adults

The State requires the following types of critical events or incidents be immediately reported for review and follow-up action by an appropriate authority by authority pursuant to RCW 74.35, Abuse of Vulnerable Adults and DDA Policies 5.13, Protection from Abuse – Mandatory Reporting and Policy 12.01, Incident Reporting and Management for DDA Employees:

- Abandonment
- Abuse (including sexual, physical and mental)
- Exploitation
- Financial exploitation
- Improper use of restraint (including physical, mechanical or chemical restraint)
- Isolation
- Neglect
- Mistreatment
- Self-neglect

Types of Abuse under RCW 74.34.020 (Abuse of vulnerable adults-Definitions)
1. Abandonment means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.
2. Abuse means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult which have the following meanings:
(a) Sexual abuse means any form of nonconsensual sexual contact including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse also includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under Chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under Chapter 71A.12 RCW, whether or not it is consensual.
(b) Physical abuse means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to: striking with or without an object, slapping, pinching, choking, kicking, shoving or prodding.
(c) Mental abuse means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing.
(d) Personal exploitation means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.
(e) Improper use of restraint means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a manner that: (i)Is inconsistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW; (ii) is not medically authorized; or (iii) otherwise constitutes abuse under this section.
3. Financial exploitation means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage. Financial exploitation includes, but it not limited to:
(a) The use of deception, intimidation, or undue influence by a person or entity in a position of trust or confidence with a vulnerable adult to obtain or use the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult;
(b) The breach of a fiduciary duty, including, but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment, that results in the unauthorized appropriation, sale, or transfer of the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or
(c) Obtaining or using a vulnerable adult's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the vulnerable adult lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds.
4. Neglect means: (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.
5. Self-neglect means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult's physical or mental health, and the absence of which impairs or threatens the vulnerable adult's well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider.

Referrals are received in any format used by the referent including email, phone calls, or postal mail and the referrals are then routed to the appropriate investigative body. Referrals for abuse, neglect, exploitation, or abandonment can be made directly to APS or the CRU through the use of the Regional APS intake line or the RCS Complaint Resolution Unit (CRU) toll-free number. The State also provides an End Harm hotline where any type of referral can be made and the referral is routed to the appropriate investigative entity.
Intake reports are first screened for the need for emergency response and the appropriate emergency responder is notified if indicated. Reports are then evaluated for jurisdiction for either Adult Protective Services or Complaint Resolution Unit, whether the intake will result in a full investigation and if so the time frames for the investigation. Reports are then prioritized and assigned for investigation as described in G 1-d.

Required reporting of allegations involving waiver participants: What, when and to whom:
RCW 74.34.035 Reports (excerpt):
(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.
(2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.
(3) When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:
(a) Mandated reporters shall immediately report to the department; and
(b) Mandated reporters shall immediately report to the appropriate law enforcement agency, except as provided in subsection (4) of this section.
(4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her or their legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:
(a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;
(b) There is a fracture;
(c) There is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or
(d) There is an attempt to choke a vulnerable adult.

DDA Electronic Incident Reporting System.
Per DDA Policy 12.01 (Incident Reporting and Management for DDA Employees), DDA staff are required to input Serious and Emergent incidents into an Electronic Incident Reporting System. Policy 12.01 applies to all DDA employees except employees of State Operated Living Alternatives (SOLA) programs and Community Crisis Stabilization Services (CCSS). For SOLA and CCSS incident reporting, DDA Policy 6.12 Incident Management and Reporting Requirements for Residential Service Providers governs reporting requirements. All DDA volunteers, interns, and work-study students are covered by DDA Policy 12.01.
DDA Policy 12.01 describes the process the Developmental Disabilities Administration (DDA) will use to protect, to the extent possible, the health, safety, and well-being of Administration clients, and to ensure that abandonment, abuse, exploitation, financial exploitation, neglect and self-neglect is reported, investigated, and resolved; and to ensure that procedures are in place to prevent abuse.
Incident types reported and tracked by DDA per Policy 12.01 include:
- Abuse
- Neglect
- Choking
- Client arrested with charges or pending charges for a violent crime
- Exploitation
- Improper use of restraint
- Criminal activity by a client
- Known criminal activity perpetrated by a DSHS employee, volunteer, licensee, or contractor
- Client-to-client abuse
- Abandonment
- Suspicious or unusual Death
- Death of client supported by RHC, SOLA or CCSS
- Death of a live-in care provider
- Suicide
- Suicide attempt
- Medication Errors
- Emergency Use of Restrictive Procedures
- Serious Injuries
- Community Protection client signs out of the program
- Client’s provider or family declines to support client after a hospital or psychiatric discharge
- Criminal Activity
- Hospitalization following an injury of unknown origin
- Inpatient admission to a state or local psychiatric hospital
- Missing clients
- Mental Health Crisis
- Natural disaster

• Known media interest or litigation

Timelines established by DDA Policy 12.01 are:
ONE-HOUR PROTOCOL
A. One-hour protocol includes:
1. A phone call to DDA central office no more than one hour after becoming aware of an incident; and
2. An incident report no more than one working day after becoming aware of an incident.
B. A DDA employee must follow one-hour protocol if any of the following occur:
1. Alleged sexual abuse of a client by a DSHS employee, volunteer, licensee, or contractor;
2. Choking – client chokes on food, liquid, or object and requires physical intervention, regardless of outcome. Examples of physical interventions include abdominal thrusts, suctioning and finder sweeps.
3. Client is missing from a CCSS, SOLA, or RHC (for all other missing clients, see one-day protocol incidents below);
4. Client is arrested with charges or pending charges for a violent crime.
5. Death of a client supported by an RHC, SOLA, or CCSS;
6. Hospitalization following an injury of unknown origin or suspected abuse or neglect;
7. Know media interest or litigation; Note: Know media interest or litigation must be reported to a Regional Administrator or Superintendent and Central Office within one hour. If the issue also meets other incident reporting criteria, follow up with an electronic incident report within one working day. Positive news stories do not require an electronic incident report.
8. Natural disaster or conditions threatening client safety or program operations;
9. Suicide;
10. A suicide attempt, which means a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior.
11. Suspicious or unusual death of a client (i.e. likely to result in investigation by law enforcement, APC, CPS, or RCS).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Developmental Disabilities Administration (DDA) works with the Aging and Long-Term Support Administration (ALTSA), the Department of Children, Youth and Families (DCYF), and the DSHS Communications Division on education efforts for clients, families and providers associated with DSHS. Washington State has designated November as Vulnerable Adult Awareness Month.
DSHS also started an End Harm campaign a number of years ago. DDA participates in this campaign which is aimed at shedding light on abuse and educating the general public as well as DSHS staff and consumers. A statewide number (1-866-EndHarm) was implemented several years ago. Anyone can call this number to report any type of abuse or neglect against a vulnerable person 24 hours per day and 7 days per week. The End Harm toll free number is promoted via news releases, the internet, DDA's Assistant Secretary's Corner and ALTSA publications. Participants receive information at least annually during their annual assessment about how to report any type of abuse or neglect of a vulnerable adult or child. The End Harm number is identified on the Meeting Wrap up form that is reviewed at the end of each annual assessment.

All providers receive mandatory reporter training. Individual and AFH/ARC providers receive training via the Fundamentals of Caregiver training. DDA residential program employees receive training from their employer. In addition, residential programs post contact information to report abuse and neglect in the participant's home.
Every DDA CRM/Social Service Specialist receives mandatory reporter/incident management training within their region. This training will be provided in each region at least once per quarter, with special emphasis and priority given to those field service employees you have recently joined the administration.

The Developmental Disabilities Administration provides information on how to report abuse, neglect, exploitation, and abandonment in multiple ways. DDA provides messaging through the GovDelivery platform to provide information to DDA employees, people receiving services, families, providers, and the public. DDA sends out a Reporting Abuse message quarterly. These messages go to any participant, caregiver, provider who is subscribed to our messaging system (over 26,000+ recipients). This message includes information on:
• How to report abuse.
• Warning signs of abuse.
• The statewide 1-866-END HARM number, to report abuse/neglect for adults and children.
• DDA’s “Do you know how to report abuse” flyer.
• Adult Protective Services information.
• Informing Families webpage that provides more information and videos on reporting abuse.

Beginning in 2024 these messages will also include videos created by Adult Protective Services and an Informing Families video that talks about what to look for and how to report abuse and neglect.
Additionally, participants receive information at least annually during their annual assessment about how to report any type of abuse or neglect of a vulnerable adult or child. The End Harm number is identified on the Meeting Wrap up form that is reviewed at the end of each annual assessment.

In 2024 DDA will have a link on the main internet page that explains “How to Report Abuse,” which will contain more information on recognizing abuse, reporting abuse and will include Adult Protective Services and the Department of Children, Youth & Families link on how to report abuse and neglect.

In 2024 the “Do you know how to report abuse” flyer will be included in the 60-day letter that is sent to clients prior to their annual assessment.

The State’s Developmental Disabilities Administration is the primary entity responsible for providing training relating to incident reporting.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Investigations of abuse, neglect, and exploitation of adults are conducted by two investigative bodies: Residential Care Services (RCS) and Adult Protective Services (APS). Investigations regarding children are conducted by Child Protective Services (CPS).

Residential Care Services: RCS has primary investigative responsibility for alleged reports of provider practice violations related to abuse, neglect, exploitation, and abandonment of vulnerable adults in all licensed and/or certified settings regulated by RCS.

RCS reviews provider systems to see if a failed practice contributed to any finding of abuse, neglect, abandonment, self-neglect, and financial exploitation. If failed provider practice is identified, RCS will issue a citation to the provider under the appropriate section of Certified Community Residential Services and Supports Chapter 388-101 WAC; Requirements for Providers of Residential Services and Supports Chapter 388-101D WAC; Adult Family Homes Chapter 388-76 WAC; Assisted Living Facility Licensing Chapter 388-78A WAC and Residential Habilitation Centers – Compliance Standards Chapter 388-111 WAC. The provider must submit and implement a corrective action plan, which is subject to on-site verification by RCS.

RCS documents their conclusion of their investigations in TIVA (Tracking Incidents for Vulnerable Adults). RCS sends the Statement of Deficiencies (the official written report document from RCS staff that identifies violations of statute(s) and/or regulations, failed facility practice(s) and relevant findings found during a complaint/incident investigation) to providers within 10 days and will document their conclusion of their investigations in TIVA within 15 days of the last day of data collection. For each allegation, the RCS investigators complete data entry into the RCS complaint investigation tracking systems and are required to record a data-qualifier in relation to the decision of the substantiated or unsubstantiated finding.

Those qualifiers are as follows for substantiated investigations:

- Federal deficiencies related to the allegation are cited
- State deficiencies related to the allegation are cited
- No deficiencies related to the allegation are cited, or
- Referral to appropriate agency

For “unsubstantiated” investigations, the following qualifiers are used:

- Allegation did not occur
- Lack of sufficient evidence
- Referral to appropriate agency

When a provider practice investigation is completed, RCS determines whether:

- The allegations are substantiated or unsubstantiated;
- The facility or provider failed to meet any of the regulatory requirements; and,
- The provider practice or procedure that contributed to the complaint has been changed to achieve and/or maintain compliance.

RCS utilizes a centralized statewide intake unit, the Complaint Resolution Unit (CRU), for the purpose of receiving reports of alleged abuse, neglect and financial exploitation for all licensed and certified Long Term Care residential providers. Referrals from the DDA incident reporting system, reports from the public and reports from mandated reporters are received and processed through this unit. RCS Field investigators receive prioritized referrals from the centralized intake unit and respond by conducting on-site investigations

RCS is centrally located in Olympia. RCS investigates licensed or certified residential providers. RCS prioritizes reports for investigation based upon on the severity and immediacy of actual or potential harm. Complaint investigation response times are 2 days, 10 days, 20 days, 45 days, or 90 days and Quality Reviews. All of these categories require an on-site investigation, except for the Quality Review category. Any situation that involves imminent danger is reported to law enforcement immediately. Any report received from a public caller is assigned an on-site investigative response time.

Adult Protective Services: Under state authority, Adult Protective Services (APS) receives reports and conducts investigations of alleged abuse (physical, mental, sexual and exploitation of person), abandonment, neglect, self-neglect and financial exploitation in order to determine whether the alleged abuse, etc. occurred and if so who was/were the perpetrator(s).

APS is located in Olympia and APS investigators are located in regional offices throughout the state. Investigations are prioritized based on the severity and immediacy of actual or potential harm. Emergent issues are referred to 911. The APS investigator meets face to face with the alleged victim within 24 hours for all reports categorized as “high; within five working days for a medium” priority report; and within ten working days for a low”priority report. A shorter response time may be assigned on a case by case basis.

APS investigations are completed within 90 days of assignment unless necessary investigation or protective services

activity continues. If a case remains in "investigating" or "investigation pending" status 90 days after intake, APS supervisors review the case at least every 30 days thereafter for the duration of the case.
The participant or the participant's representative is informed of the results of the investigation. For unsubstantiated results the participant/representative receives verbal notification at the end of the investigation. For substantiated results, the participant receives verbal notification (written when requested) at two stages throughout the investigation; (1) when a determination by the investigator to recommend that the allegation be substantiated and (2) when this determination has been reviewed by the regional reviewing authority.

Child Protective Services: Under state authority, Child Protective Services (CPS) within the Department of Children, Youth and Families (DCYF) is responsible for receiving and investigating reports of suspected child abuse and neglect. The primary purpose of the CPS program is to assess risk of child maltreatment rather than to substantiate specific allegations of child abuse and neglect. Any referral received from a commissioned law enforcement officer stating a parent has been arrested for Criminal Mistreatment in the fourth degree under RCW 9A.42 is screened in and assigned for investigation.
When someone reports that a child may be abused or neglected, CPS is required by law to investigate. A report of suspected child abuse or neglect could be made to CPS or the police. Even though CPS staff and the police work together, they make separate investigations. CPS conducts family assessments, and the police conduct criminal investigations.
Upon receipt of a report concerning the possible occurrence of abuse and/or neglect, CPS begins a risk assessment. The risk assessment begins with a review of the information with the reporter to determine if there is sufficient information to locate the child; identify the perpetrator as a parent or caretaker; and determine whether the allegation is a situation of child abuse or neglect or there is a risk of harm to the child. Referrals which are determined to contain sufficient information may be assigned for investigation or other community response.
CPS workers must complete the intake process with referral information recorded in the FamLink (DCYF case management system) within:

a. 4 hours from the date and time DCYF receives the following referrals:
   1. Emergent CPS or DLR (Division of Licensed Resources)/CPS
   2. Family Reconciliation Services (FRS)
b. 4 business hours (business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday) from the date and time DCYF receives Non-Emergent CPS or DLR/CPS referrals.
c. 2 business days from the date and time DCYF receives the following referrals:
   1. Information Only
   2. CPS - Alternate Intervention
   3. Third Party
   4. Child Welfare Services (CWS)
   5. Licensing Complaint
   6. Home Study

If additional victims identified during the course of an investigation are determined:

a. To be at risk of imminent harm, a social worker will have face to face contact within 24 hours from the date and time they are identified.
b. NOT to be at risk of imminent harm, a social worker will have face to face contact within 72 hours of the date and time they are identified.

The assigned social worker must:

a. Contact the referrer if the intake information is insufficient or unclear and may provide information about the outcome of the case to mandated referrers.
b. Conduct a face-to-face investigative interview with child victims within 10 calendar days from date of referral.

CPS is a continuum of protection consisting of different but complementary functions. Intervention designed to protect children from abuse and neglect must include permanency planning goals from the onset of the case and must be updated at 90-day intervals.
When it appears that a child is in danger of being harmed, or has already been seriously abused or neglected, a police officer can place the child in protective custody. Custody of the child is then transferred to CPS, which places the child with a relative or in foster care. By law, a child can be kept in protective custody for no more than 72 hours, excluding weekends and legal holidays. If the child is not returned to the parents or some other voluntary arrangement made within

72 hours, the matter must be reviewed by a court.
In very serious cases of abuse and neglect, a child can be removed permanently from the parents (i.e., termination of parental rights). When this happens the child becomes legally free through a court procedure. The parent no longer has any rights or responsibilities toward the child. If a parent voluntarily gives up a child for adoption, this is called relinquishing parental rights.
Child Welfare Services (CWS) within the DCYF provides services to children and families with long-standing abuse and neglect problems. Typically these children have been removed from the family home and are in the foster care system. The focus of CWS is to achieve a permanent plan and placement for these children as soon as possible.
CPS seeks to complete investigations within 45 days, but it may take up to 90 days if law enforcement is involved. Outcome notices are sent to relevant parties upon investigation completion.
CPS, RCS and APS are using the FamLink (DCYF case management system) and TIVA (Tracking Incidents for Vulnerable Adults) systems to document investigation activities including intake of complaints and outcome reports. There is an electronic connection between FamLink/TIVA and the CARE system to notify case managers of a) complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that is identified in the individual's CARE record.
The Aging and Long-Term Support Administration receives nightly data feeds from the TIVA (Tracking Incidents for Vulnerable Adults) system that are used in this ALTSA/DDA reporting system. TIVA information is reviewed to determine if client information matches DDA waiver participants who are identified in CARE. DDA uses this reporting system to address specific programmatic and provider issues from the outcomes of the waiver clients who were involved in investigations by Residential Care Services (RCS), Adult Protective Services (APS) and/or Child Protection Services (CPS) for whom a report of abuse, neglect, abandonment, or financial exploitation was substantiated. The data are broken out by type of incident and provider type.
Continued at Main.B.Optional.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Under state authority, Child Protective Services (CPS) within the Department of Children, Youth and Families (DCYF) is responsible for receiving and investigating reports of suspected child abuse and neglect.
When someone reports that a child may be abused or neglected, CPS is required by law to investigate. A report of suspected child abuse or neglect could be made to CPS or the police. Even though CPS staff and the police work together, they make separate investigations. CPS conducts family assessments, and the police conduct criminal investigations.
Residential Care Services is responsible for overseeing the certification of all certified residential programs. Mandatory reporting, and mandatory reporter training are among the standards they evaluate per Washington Administrative Code. Certification occur a minimum of every two years, but the certification length can be reduced depending on the regulatory concerns.
DDA, utilizing contracted evaluators, is responsible to complete the certification reviews for Alternative Living, Companion Homes, Overnight Planned Respite, Children's SOLA, and Community Crisis Stabilization Services.
RCS Field Managers (supervisors) review prioritized complaints assigned from the centralized intake unit. As needed, supervisors work directly with investigative staff in developing investigative plans and may assist investigators with coordination activities.
The RCS Assistant Director and the Quality Assurance (QA) Administrator receive copies of serious and immediate complaint intakes at the same time that the initial referrals are sent from CRU to the field. Both of these individuals monitor the progress of investigative response to these incidents.
RCS Field Managers review the results of all investigated complaints; ensure that investigation activities were thorough and complete and that no follow-up activities are required. Field Managers also make recommendations to HQ and assist with coordination of enforcement activities.
RCS provider practice substantiation rates are monitored by DDA through data pulled from the TIVA (Tracking Incidents for Vulnerable Adults) system. Intakes and investigations can be reviewed by program, by type, and by facility. Trends and patterns are identified and analyzed to determine if substantiated areas of non-compliance negatively impacted waiver clients living in the licensed or certified setting. Analyses include a review of the general scope and severity of the non-compliance, and whether or not RCS enforcement processes resulted.
RCS and the Aging and Long-Term Support Administration are using the TIVA system to document investigation activities including intake of complaints and outcome reports. There is an electronic connection between the TIVA and the CARE system to notify case managers of a) complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that is identified in the individual's CARE record.
DDA requires serious and emergent incidents to be entered into a statewide electronic incident reporting system per DDA Policy. Incidents are entered into the system by DDA CRMs and Social Service Specialists with notification sent to appropriate staff. DDA's Incident Reporting Application data is used to develop statewide training for case/resource managers and the community on trends and issues concerning abuse, neglect, abandonment, exploitation and suspicious deaths of children and adults.

Adult Protective Services (APS) is a statewide program within the operating agency. The intakes, investigations and protective services performed by APS are continuously monitored at both the state and the regional levels. For example:
- Regional supervisors and program managers conduct on-going quality assurance audits of APS case records.
- The APS program has implemented a statewide QA monitoring process that includes record reviews and a formal in-person skills evaluation conducted by a supervisor during an actual APS investigation.
- Several reports based on data pulled from the statewide APS data base are routinely generated and evaluated at least annually by program managers and upper management at the state office.
- The regions use a report system tool that enables them to create customized reports pulled from the statewide data base to track, monitor and evaluate implementation of APS in their region.

DDA Regional Quality Assurance staff in all three regions provides ongoing monitoring of the DDA Incident Reporting application. The Central Office Incident Program Manager is responsible for the monitoring and oversight of all significant incidents. A Central Office Incident Report team meets monthly to review aggregate data, trends and patterns and staff incidents of particular concern.
Aggregate data analyzed by DDA Central Office is also sent out to the regions for follow up. Regional analysis is tracked and discussed at the Regional Quarterly Quality Assurance Meeting. Best practices and significant issues are presented to the Full Management Team four times per year.
Information and findings are communicated to the Medicaid agency at least quarterly via the HCA Medicaid Agency Waiver Management Committee.

The Developmental Disabilities Administration oversees the operation of the DDA Incident Report system. The Aging

and Long-Term Support Administration oversees the operation of the Adult Protective Services. The Department of Children, Youth and Families oversees the operation of Child Protective Services.

DDA has multiple methods for conducting system-wide oversight and trending analysis. We have reports that are pulled and reviewed on a regular basis that helps identify and prevent incidents.
Incident Report Reviewing Process
DDA reviews every critical incident report that comes through the incident reporting system. Each region has Quality Assurance Program Managers that monitor their own regions incident reporting inbox. Headquarters has an incident reporting inbox that receives every incident report statewide. We review every incident report to ensure:
• Accuracy.
• Incident meets policy criteria.
• Notifications are sent to the appropriate investigative agencies.

Incident Reporting Committee
The DDA Incident Reporting Committee meets monthly and consists of Program and Unit managers from different teams within Central Office. The committee's goal is to review and analyzes incident report data to identify any statewide trends. The committee reviews different incident types monthly to see if there are any trends or patterns. If trends or patterns are identified the Incident Management Program Manager will follow up with the Regional Quality Assurance Managers with any committee recommendations. Recommendations can be client specific and or more broad quality assurance strategies, recommendations are monitored to ensure that follow up was taken.

Incident Reporting and Emergency Room Medicaid Claims
This report is pulled quarterly, it was developed to review Emergency Room and Hospital admission claims to ensure incidents are reported to DDA as required by DDA incident management policies 6.12 Incident Management and Reporting Requirements for Residential Service Providers and 12.01 Incident Reporting and Management for DDA Employees so that appropriate follow-up and client support can occur. Emergency room and hospital admissions that meet criteria for an incident report must have an one completed by the DDA Case Resource Manager.

Four or More Similar Incident Report
This report is pulled quarterly and reviewed by the Regional Quality Assurance Managers. The purpose of this report is to review clients with four or more similar incidents. The focus is on prevention of future incidents.

30-Day Follow-Ups
Incidents involving alleged or suspected abuse, improper use of restraint, neglect, personal or financial exploitation or abandonment, DDA staff must follow up with the client, their legal representative, and the service provider, when involved, within 30 days of the DDA aware date. DDA staff must document this contact in the incident report follow-up and determine if health and welfare actions have been taken as planned or if plans are moving forward as expected, and if the actions planned and taken have been appropriately implemented to the satisfaction of the client, the client's legal representative. Headquarters and Regional Quality Assurance Managers send reports throughout the month to Case Resource Managers that identify incidents that need to be followed up on.

Provider IR Timely Reporting
The purpose of this report is to figure out which providers are out of compliance with their reporting obligations. The report shows late and timely reporting. For late reporting we look at the date the incident occurred and how long it took for DDA to be made aware of the incident. We review provider types that are required to report incidents per policy 6.12 Incident Management and Reporting Requirements for Residential Service Providers. The Regional Quality Assurance Managers will work with the agencies that have a high number of late incident reports to determine if they need support and possible training. This report is pulled quarterly.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Safeguards that address methods for detecting the unauthorized use of restraints include a robust case management system with eyes-on visits with clients during annual assessments and significant change assessments, periodic monitoring visits, consultations with nursing care consultants, service provider reports, incident reports, complaints to Adult Protective Service, Children's Protective Service and Compliant Resolution Unit, law enforcement reports, and Ombuds reports.

Introduction:
The following information is applicable to paid providers and licensed/certified settings that are available to waiver participants for respite care and to all residential providers. DDA safeguards concerning the use of each type of restraint do not apply to family members (e.g., parents, siblings, relatives) unless they are paid providers of the Department of Social and Health Services.
Protections against the inappropriate use of restraints and restrictive procedures are contained in state law and rules concerning abuse and neglect (i.e., as described in Appendix G-1).
The Positive Behavior Support Plan:
The basic tool used by the DDA to address challenging behaviors is the Positive Behavior Support Plan (PBSP). PBSPs are in addition to the individualized person-centered service plan and DDA Policy 5.14 Positive Behavior Support Principles provides guidance to staff.

A PBSP consists of the following sections:
a. Prevention Strategies;
b. Teaching/Training Supports;
c. Strategies for Responding to Challenging Behaviors; and
d. Data Collection and Monitoring.

PBSPs are specifically required when:
1. The use of certain restrictive interventions is planned or used. DDA Policies 5.15 Restrictive Procedures - Community, 5.19 Positive Behavior Support for Children and Youth, and 5.20 Restrictive Procedures and Physical Interventions with Children and Youth provide more information regarding PBSPs.
2. An individual is taking psychoactive medications to reduce challenging behavior or treat a mental illness. DDA Policy 5.16 Use of Psychotropic Medications provides more information.
3. Certain restrictive physical interventions are planned or used. DDA Policies 5.17 Physical Intervention Techniques and 5.20 Restrictive Procedures and Physical Interventions with Children and Youth contain more information.

When challenging behaviors are identified, a written Functional Assessment governed by DDA Policy 5.21 Functional Assessments and Positive Behavior Support Plans and PBSP must be completed within ninety (90) days. All PBSPs must be agreed to by the individual or legally responsible individual.
Conditions under which a restraint may be applied:
Physical restraints, mechanical devices used as a restraint and chemical restraints may be used solely to treat a participant's behavior that poses a safety or health risk. Per DDA policy, restraints may not be used for the purposes of discipline or convenience.
The use of mechanical or physical restraints during medical and dental treatment is acceptable if under the direction of a physician or dentist and consistent with standard medical/dental practices. DDA Policy 5.17 Physical Intervention Techniques provides additional detail.
Identification of a specific and individualized assessed need:
If a restraint is to be used to treat challenging behavior, it must be supported by a functional assessment as described in DDA Policy 5.21 Functional Assessments and Positive Behavior Support Plans. All Functional Assessments must contain four major sections:
- Description and Pertinent History;
- Definition of Challenging Behavior(s);
- Data Analysis/Assessment Procedures; and
- Summary Statements.

Based on the Functional Assessment, a written Positive Behavior Support Plan is implemented to reduce or eliminate the individual's need to engage in the challenging behavior(s).

Informed Consent:

The use of restraints is voluntary and the participant or representative must give informed consent, which is documented in the individual's PCSP and PBSP. The participant or representative is always included in the development of the person centered service plan, as well as a PBSP. The participant or representative is made aware of the risks and the right to refuse the restraint. The participant or legal guardian has the right to refuse any service (including the use of restraints) or medication at any time.
Positive interventions, supports and less intrusive methods must be employed prior to the use of restraints:
Prior to the use of restraints, alternative strategies must be tried. The person-centered service plan contains positive and less intrusive interventions that must be employed for any identified behavior. The participant's negotiated care plan includes strategies, therapeutic interventions, and required staff behavior to address the symptoms for which the restraint is prescribed. The plan addresses a participant's special needs and responses to a participant's refusal of care and the need to reduce tension, agitation or anxiety. The provider must document in the negotiated care plan other strategies or modifications used to avoid restraints.

When a waiver participant receives psychotropic medication, non-pharmaceutical supports used to assist in the treatment of the individual's symptoms or behaviors must be documented in the individual's Positive Behavior Support Plan.
Participants must have an assessed need proportionate to the use of restraints:
The need for a restraint must be assessed by a specialist in challenging behaviors. This information must then be incorporated into the participant's PCSP, the Functional Assessment that details the challenging behaviors and their precursors, and the PBSP. The conditions under which a restraint may be used must be documented in the participant's PCSP and PBSP. Documentation must reflect the symptom related to behavior for which a restraint is being used, when a restraint may be used, and how the restraint should be used.
The use of chemical restraints is governed by DDA Policies 5.15 and 5.16. If the waiver participant appears to be displaying symptoms of mental illness and/or persistent challenging behavior, any physical, medical, or dental conditions that may be causing or contributing to the behavior must first be considered.
If no physical or other medical condition is identified, then a psychiatric assessment is conducted. After the assessment, if the treatment professional recommends psychoactive medication, the prescribing professional or agency staff documents this in a Psychotropic Medication Treatment Plan (PMTP). The plan must include the following:

a. A description of the behaviors, symptoms or conditions for which the medication is prescribed;
b. The name, dosage, and frequency of the medication;
c. The length of time considered sufficient to determine if the medication is effective;
d. The behavioral criteria to determine whether the medication is effective; and
e. The anticipated schedule of visits with the prescribing professional.

Collection and review of data to measure the ongoing effectiveness of the restraint:
Per DDA Policy 5.14 and 5.21, the PBSP must:

- Operationally define the goals of the PBSP in terms of specific, observable behaviors.
- Indicate what data is needed to evaluate success (e.g., frequency, intensity and duration of target behaviors).
- Provide instructions to staff or caregivers on how to collect this data (e.g., forms, procedures) i.e., frequency, intensity and duration.
- List who will monitor outcomes, need for revisions, and evaluate success and process for monitoring.
- Recommend displaying data in a graph over time for easy analysis.

Per DDA Policies 5.15, Restrictive Procedures: Community and 5.20, Restrictive Procedures and Physical Interventions with Children and Youth, the program staff responsible for PBSPs must review the plan at least every thirty (30) days. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the PBSP must be reviewed and revisions implemented as needed.

Per DDA Policy 5.16 Psychotropic Medications, with respect to psychoactive medication the prescribing professional should see the individual at least every three (3) months. The continued need for the medication and possible reduction in medication is assessed at least annually by the prescribing professional.
Periodic review of restraint usage:
The PCSP and PBSP must be reviewed at least annually (and in the case of positive behavior support and consultation provider to children and youth in the family home, providers must submit quarterly progress

reports) and updated at any time the use of a restraint (including psychoactive medication) becomes ineffective, is no longer needed or becomes unsafe.

When challenging behaviors are identified, a written Functional Assessment and PBSP must be completed within ninety (90) days. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the FA and the PBSP must be reviewed and revisions implemented as needed.

Restraints may not cause harm:

The use of restraints must be deemed safe and appropriate per DDA policies concerning the use of restraints and restrictive procedures. The waiver participant or representative is informed of any risks and may choose to decline the use of restraints at any time.

Education and training requirements for providers involved in the use of restraints:

All staff using physical interventions must have prior training in the use of such techniques according to the facility or agency's policy and procedures. Staff must also receive training in crisis prevention techniques and positive behavior support. Staff receiving physical intervention techniques training must complete the course of instruction and demonstrate competency before being authorized to use the techniques with waiver participants. All residential service providers must have documentation of prior training in the use of physical intervention techniques.

A review of de-escalation techniques and physical intervention techniques with all service providers and members of a child/youth's support team must occur annually before continuing to be used with the child/youth.

Regarding the use of psychotropic medications, staff and family members are informed of the anticipated impact of the medication and its potential side effects. Staff and/or family members monitor the waiver participant to determine if the medication is being effective and communicate when it is not effective to the prescribing professional.

References:

- DDA Policy 5.11: Restraints
- DDA Policy 5.14: Positive Behavior Support Principles
- DDA Policy 5.15: Restrictive Procedures: Community
- DDA Policy 5.16: Psychotropic Medications
- DDA Policy 5.17: Physical Intervention Techniques
- DDA Policy 5.19: Positive Behavior Support for Children and Youth
- DDA Policy 5.20: Restrictive Procedures and Physical Interventions with Children and Youth
-DDA Policy 5.21: Functional Assessments and Positive Behavior Support Plans

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Social and Health Services (DSHS) through the Aging and Long-Term Support Administration (ALTSA) and the Department of Children, Youth and Families (DCYF) through Child Protective Services (CPS) is responsible for investigating the unauthorized use of restraints.
Under state authority RCW 74.34, ALTSA Residential Care Services receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for individuals enrolled with the Developmental Disabilities Administration. ALTSA's Adult Protective Services (APS) investigates the perpetrators of abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, supported living programs and adults residing in their own homes.
Under state authority contained in Chapter 26.44 RCW, CPS within the Department of Children, Youth and Families (DCYF) is responsible for receiving and investigating reports of suspected child abuse and neglect.
DDA monitors the use of unauthorized restraints and takes corrective action through:

- Reports received in the DDA Incident Reporting system,
- Reports submitted to APS,
- Reports submitted to RCS,
- Reports submitted to CPS,
- The face to face DDA Assessment process conducted yearly and at times of significant change,
- The DDA grievance process, and
- DDA Quality Assurance activities that include face to face interviews of clients and review of complaints.

RCS and APS are using the TIVA system to document investigation activities including a) intake of complaints and b) outcome reports. There is an electronic connection between the FamLink and the CARE system to notify case managers of a) complaints concerning treatment of children that are referred for investigations and b) investigation outcomes. This is an electronic notification that is included in the individual's CARE record.
DDA Policies 5.11, 5.14, 5.15, 5.16, 5.17, 5.19, 5.20 and 5.21 (see G-2.b.i) specify the requirements for the use and documentation of any type of restraint (mechanical or pharmacological). Only the least restrictive intervention needed to adequately protect the individual, others, or property may be used, and must be terminated as soon as the need for protection is over. Approved restraint use must be fully documented and reviewed at least monthly by the residential provider and at least quarterly by the waiver participant's interdisciplinary team. Any emergency use of a restraint requires an incident report to DDA headquarters where it is reviewed by the Incident Management Program Manager.
RCS has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.
Quality Compliance Coordinator (QCC) staff review yearly the positive behavior support plans (PBSPs) of a sample of waiver participants. One focus is on instances in which the PBSP includes a restraint that requires approval through an exception to rule (ETR). When the QCC team identifies PBSPs requiring an ETR that did not have an ETR, the QCC team verifies that individual corrective action was completed within 90 days and reports to DDA management on any systems issues.

DDA's Incident Report Application generates reports that permit management to periodically review incidents and to categorize incidents by type, location, provider involvement, hospitalization, and outcome and to identify trends and patterns. Based on these trends and patterns, improvement strategies can be developed and implemented.
DDA's Incident Report Application is overseen by a dedicated program manager who meets regularly with regional quality assurance staff and senior management to review incident management reports, review response times for incident follow-up and identify trends and patterns that require management action and improvement strategies.

References:
-Chapter 26.44 RCW: Abuse of Children
-Chapter 74.34 RCW: Abuse of Vulnerable Adults
-DDA Policy 5.11: Restraints
-DDA Policy 5.14: Positive Behavior Support Principles
-DDA Policy 5.15: Restrictive Procedures: Community
-DDA Policy 5.16: Psychotropic Medications
-DDA Policy 5.17: Physical Intervention Techniques
-DDA Policy 5.19: Positive Behavior Support for Children and Youth

-DDA Policy 5.20: Restrictive Procedures and Physical Interventions with Children and Youth
-DDA Policy 5.21: Functional Assessments and Positive Behavior Support Plans

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

DDA Policy 5.15 Restrictive Procedures: Community lists the following permitted restrictive procedures that must be addressed in the client's function assessment and positive behavior support plan: 1) requiring a client to leave an area with physical coercion for protection of the client, others, or property; 2) using door or window alarms to monitor clients who present a risk to others, such as being sexually or physically assaultive; 3) necessary supervision to prevent dangerous behavior; 4) taking away items that could be used as weapons when client has a documented history of making threats or inflicting harm with those or similar items, such as knives, matches, lighters, etc.; 5) removing client property being used to injure one's self, others, or property; 6) physical restraint to prevent the free movement of part or all of the client's body with the exception of seated restraints, which require an ETP, and prohibited restraints; and 7) mechanical restraint used to limit the client's free movement or prevent the client from self-injury when the client cannot independently remove the device, such as a helmet, arm splints, seatbelts use outside of a motor vehicle, etc.

Methods for detecting the unauthorized use of restrictive interventions include a robust case management system with eyes-on visits with clients during annual assessments and significant change assessments, periodic monitoring visits, consultations with nursing care consultants, service provider reports, incident reports, complaints to Adult Protective Service, Children's Protective Service and Compliant Resolution Unit, law enforcement reports, and Ombuds reports.

Introduction:
The following information is applicable to paid providers and licensed/certified settings that are available to waiver participants for respite care, as well as to providers of in-home Positive Behavior Support and Consultation. DDA safeguards concerning the use of restrictive interventions do not apply to family members (e.g., parents, siblings, relatives) unless they are paid providers of the Department of Social and Health Services.
Protections against the inappropriate use of restraints and restrictive interventions are contained in state law and rules concerning abuse and neglect (i.e., as described in Appendix G-1).
The Positive Behavior Support Plan:
The basic tool used by the DDA to address challenging behaviors is the Positive Behavior Support Plan (PBSP). PBSP's are in addition to the individualized person-centered plan.
A written PBSP must have the following sections:
a. Prevention Strategies;
b. Teaching/Training Supports;
c. Strategies for Responding to Challenging Behaviors; and
d. Data Collection and Monitoring.

PBSPs are specifically required when:
1. The use of certain restrictive interventions is planned or used. DDA Policy 5.15, Restrictive Procedures: Community, DDA Policy 5.19, Positive Behavior Support for Children & Youth, and DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth, provide more information and requirements regarding PBSPs.
2. An individual is taking psychotropic medications to reduce challenging behavior or treat a mental illness. DDA Policy 5.16, Psychotropic Medications provides more information.
3. Certain restrictive physical interventions are planned or used. DDA Policy 5.17, Physical Intervention Techniques, and DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth, contain more information and related requirements.
When challenging behaviors are identified, a written Functional Assessment and PBSP must be completed within ninety (90) days. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the FA and the PBSP must be reviewed and revisions implemented as needed.
All PBSPs must be agreed to by the individual or legally responsible individual.
Conditions under which a restrictive intervention may be applied:
As listed in DDA Policy 5.15, Restrictive Procedures: Community, the following are not permitted under any circumstances:
1. Restraint chairs;
2. Restraint boards;
3. Exclusionary time out;
4. Corporal or physical punishment;
5. Forced compliance, including exercise, when it is not for protection;

6. Locking a client alone in a room;
7. Overcorrection;
8. Physical or mechanical restraint in a prone position (i.e. the client is lying on their stomach);
9. Physical or mechanical restraint in a supine position (i.e. the client is lying on their back);
10. Removing, withholding, or taking away money, tokens, points, or activities that a client has previously earned;
11. Requiring a client to re-earn money, token, points, activities, or item purchased previously;
12. Withholding or modifying food as a consequence for behavior (e.g. withholding dessert because the client was aggressive);
13. Chemical restraint;
14. A posey bed, also known as a tent bed; and
15. Aversive stimulation.

Per DDA Policy 5.15, Restrictive Procedures: Community, restrictive interventions may only be used for the purpose of protection, and may not be used for the purpose of changing behavior in situations where no need for protection is present. The participant or legal guardian has the right to refuse any service (including the use of restrictive interventions) at any time.
Identification of a specific and individualized assessed need:
If a restraint is to be used to treat challenging behavior, it must be supported by a functional assessment as described in DDA Policy 5.21, Functional Assessments and Positive Behavior Support Plans. All Functional Assessments must contain four major sections:
- Description and Pertinent History;
- Definition of Challenging Behavior(s);
- Data Analysis/Assessment Procedures; and
- Summary Statements.

Based on the Functional Assessment, a written Positive Behavior Support Plan is implemented to reduce or eliminate the client's need to engage in the challenging behavior(s).
Informed Consent:
The use of restrictive interventions is voluntary and the participant or representative must give informed consent, which is documented in the individual's PCSP and PBSP. The participant or representative is always included in the development of the person-centered service plan, as well as a PBSP. The participant or representative is made aware of the risks and the right to refuse the restrictive intervention. The participant or legal guardian has the right to refuse any service (including the use of restrictive interventions) or medication at any time.
Positive interventions, supports and less intrusive methods must be employed prior to the use of restrictive interventions:
Prior to the use of restrict interventions, alternative strategies must be tried. The person-centered service plan contains positive and less intrusive interventions that must be employed for any identified behavior. The participant's negotiated care plan includes strategies, therapeutic interventions, and required staff behavior to address the symptoms for which the restrictive intervention is prescribed. The plan addresses a participant's special needs and responses to a participant's refusal of care and the need to reduce tension, agitation or anxiety. The provider must document in the negotiated care plan other strategies or modifications used to avoid restrictive interventions.
Participants must have an assessed need proportionate to the use of restrictive interventions:
The need for a restrictive intervention must be assessed by a specialist in challenging behaviors. This information must then be incorporated into the participant's PCSP, the Functional Assessment that details the challenging behaviors and their precursors, and the PBSP. The conditions under which a restrictive intervention may be used must be documented in the participant's PCSP and in the PBSP. Documentation must reflect the symptom related to behavior for which a restrictive intervention is being used, when a restrictive intervention may be used, and how the restrictive intervention should be used.

Restrictive interventions must be used only as provided for in DDA Policy 5.15., Restrictive Procedures: Community, DDA Policy 5.17, Physical Intervention Techniques, and DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth.
- Restrictive interventions must be used only when positive or less restrictive techniques or procedures have been tried and are determined to be insufficient to protect the client, others, or damage to the

property of others.
• Restrictive interventions may only be used for the purpose of protection and may not be used for the purpose of changing behavior in situations where no need for protection is present.
• Only the least restrictive intervention needed to adequately protect the client, others, or property must be used, and terminated as soon as the need for protection is over.
Collection and review of data to measure the ongoing effectiveness of the restrictive intervention:
Per DDA Policy 5.14, Positive Behavior Support Principles, the PBSP must address the following:
• Operationally define the goals of the PBSP in terms of specific, observable behaviors.
• Indicate what data is needed to evaluate success (e.g., frequency, intensity and duration of target behaviors).
• Provide instructions to staff or caregivers on how to collect this data (e.g., forms, procedures) i.e., frequency, intensity and duration.
• List who will monitor outcomes, need for revisions, and evaluate success and process for monitoring.
• Recommend displaying data in a graph over time for easy analysis.

Per DDA Policy 5.15, Restrictive Procedures: Community, and DDA Policy 5.20, Restrictive Procedures and Physical Interventions with Children and Youth, program staff responsible for PBSPs must review the plan at least every thirty (30) days. If the data indicates progress is not occurring after a reasonable period, but no longer than six (6) months, the PBSP must be reviewed and revisions implemented as needed.
Periodic review of restrictive intervention usage:
The PCSP and PBSP must be reviewed at least annually (and in the case of positive behavior support and consultation provider to children and youth in the family home, providers must submit quarterly progress reports) and updated at any time the use of a restrictive intervention becomes ineffective, is no longer needed or becomes unsafe.
A post-analysis (i.e., a debriefing to review the incident and assess what could have been done differently) must take place whenever restrictive interventions are implemented in emergencies or when the frequency of use of the intervention is increasing. The child/youth, service providers involved, supervisor (in residential settings), parent/guardian, and other team members must participate, as appropriate. The DDA case resource manager must document the post-analysis in a service episode record (SER) in the client's record.

Restrictive interventions may not cause harm:
The use of restrictive interventions must be deemed safe and appropriate per DDA policies concerning the use of restrictive procedures. The waiver participant or representative is informed of any risks and may choose to decline the use of restrictive interventions at any time.
Education and training requirements for providers involved in the use of restrictive interventions:
All staff using restrictive interventions must have prior training in the use of such techniques according to the facility or agency's policy and procedures. With all training on the use of restrictive interventions, staff must also receive training in crisis prevention techniques and positive behavior support. Staff receiving restrictive intervention techniques training must complete the course of instruction and demonstrate competency before being authorized to use the techniques with waiver participants. All residential service providers must have documentation of prior training in the use of restrictive intervention techniques.
A review of de-escalation techniques and physical intervention techniques with all service providers and members of a child/youth's support team must occur annually before continuing to be used with the child/youth.
Restrictive intervention systems must include, at a minimum, the following training components:
1. Principles of positive behavior support, including respect and dignity;
2. Communication techniques to assist a child/youth to calm down and resolve problems in a constructive manner;
3. Techniques to prevent or avoid escalation of behavior;
4. Techniques for providers and parents/guardians to use in response to their own feelings or expressions of fear, anger, or aggression;
5. Techniques for providers and parents/guardians to use in response to the child/youth's feelings of fear or anger;
6. Instruction that restrictive intervention techniques may not be modified except as necessary in consideration of individual disabilities, medical, health, and safety issues. An appropriate medical/health professional and a certified trainer or behavioral specialist must approve all modifications;
7. Evaluation of the safety of the physical environment at the time of the intervention;

8. Use of the least restrictive interventions depending upon the situation;
9. Clear presentation and identification of prohibited and permitted restrictive intervention techniques as outlined in this policy;
10. Discussion of the need to release a child/youth from any physical restraint as soon as possible;
11. Instruction on how to support restrictive interventions as an observer and recognize signs of distress by the child/youth and fatigue by the staff; and
12. Discussion of the importance of complete and accurate documentation by service providers.

References:
-DDA Policy 5.11: Restraints
-DDA Policy 5.14: Positive Behavior Support Principles
-DDA Policy 5.15: Restrictive Procedures: Community
-DDA Policy 5.16: Psychotropic Medications
-DDA Policy 5.17: Physical Intervention Techniques
-DDA Policy 5.19: Positive Behavior Support for Children and Youth
-DDA Policy 5.20: Restrictive Procedures and Physical Interventions with Children and Youth
-DDA Policy 5.21: Functional Assessments and Positive Behavior Support Plans

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Social and Health Services (DSHS) through the Aging and Long-Term Support Administration (ALTSA) and the Department of Children, Youth and Families through Child Protective Services (CPS) is responsible for detecting the unauthorized use of restrictive interventions.
Under state authority RCW 74.34, the ALTSA receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Developmental Disabilities Administration. ALTSA Residential Care Services (RCS) investigates the role of provider systemic issues regarding abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, & supported living programs. ALTSA Adult Protective Services (APS) investigates the perpetrators of abuse and neglect involving adults.
Under state authority contained in Chapter 26.44 RCW, Child Protective Services (CPS) within the Department of Children, Youth and Families (DCYF) is responsible for receiving and investigating reports of suspected child abuse and neglect.
DDA's Incident Report Application generates reports that permit management to periodically review incidents and to categorize incidents by type, location, provider involvement, hospitalization, and outcome and to identify trends and patterns. Based on these trends and patterns, improvement strategies can be developed and implemented.
DDA detects use of unauthorized restrictive intervention through:

- Reports submitted to APS,
- Reports submitted to RCS,
- Reports submitted to CPS,
- Reports received in the DDA Incident Reporting application,
- The face to face DDA Assessment process conducted yearly and at times of significant change,
- The DDA grievance process, and
- DDA Quality Assurance activities that include face to face interviews of clients and review of complaints.

RCS and APS are using the TIVA (Tracking Incidents for Vulnerable Adults) system to document investigation activities including: a) intake of complaints and, b) outcome reports. There is an electronic connection between the FamLink (DCYF case management system) and the CARE system to notify case managers of: a) complaints concerning treatment of children that are referred for investigations, and b) investigation outcomes. This is an electronic notification that is included in the individual's CARE record.
DDA Policies 5.14, 5.15, 5.16, 5.17, 5.19, 5.20 and 5.21 (see G-2.b.i) specify the requirements for using and documenting use of any type of restrictive intervention. Only the least restrictive intervention needed to adequately protect the client, others, or property may be used, and terminated as soon as the need for protection is over. The use of approved restrictive interventions must be fully documented and reviewed at least monthly by the residential provider and at least quarterly by the waiver participant's interdisciplinary team. Any emergency use of a restrictive interventions requires an incident report to DDA headquarters where it is reviewed by the Incident Management Program Manager.
Residential Care Services (RCS) Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive interventions, or use of psychoactive medications.
Quality Compliance Coordinator (QCC) staff yearly review the positive behavior support plans (PBSPs) of a sample of waiver participants. One focus is on instances when the PBSP includes a restraint that requires approval through an exception to rule (ETR). When the QCC team identifies PBSPs requiring an ETR that did not have an ETR, the QCC team verifies that individual corrective action was completed within 90 days and reports to management on systems issues.
References:
-Chapter 26.44 RCW: Abuse of Children
-Chapter 74.34 RCW: Abuse of Vulnerable Adults
-DDA Policy 5.11: Restraints
-DDA Policy 5.14: Positive Behavior Support
-DDA Policy 5.15: Restrictive Procedures: Community
-DDA Policy 5.16: Psychotropic Medications
-DDA Policy 5.17: Physical Intervention Techniques
-DDA Policy 5.19: Positive Behavior Support for Children and Youth
-DDA Policy 5.20: Restrictive Procedures and Physical Interventions with Children and Youth
-DDA Policy 5.21: Functional Assessments and Positive Behavior Support Plans

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department of Social and Health Services:
- Developmental Disabilities Administration (DDA)
- Aging and Long-Term Support Administration/Residential Care Services (RCS)
- Aging and Long-Term Support Administration/Adult Protective Services (APS)

The Department of Children, Youth and Families:
- Child Protective Services (CPS)

Under state authority RCW 74.34, the Aging and Long-Term Support Administration (ALTSA) receives reports and conducts investigations of abuse, neglect, exploitation and abandonment for clients enrolled with the Developmental Disabilities Administration. ALTSA's Residential Care Services (RCS) investigates the role of provider systemic issues in abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, & supported living programs. ALTSA's Adult Protective Services (APS) investigates the perpetrators of abuse and neglect involving adults.

The DDA detects use of unauthorized restrictive intervention through:
- Reports submitted to APS,
- Reports submitted to RCS,
- Reports submitted to CPS,
- Reports received in the DDA Incident Reporting application,,
- The face to face DDA Assessment process conducted yearly and at times of significant change,
- The DDA complaint/grievance process, and
- DDA Quality Assurance activities that include face to face interviews of clients and review of complaints.

Residential Care Services Division has contracted evaluators who evaluate the residential agencies/programs at least once every two years. Their review always includes any use of restraints, restrictive procedures, or use of psychoactive medications.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

All participants receive monitoring by case resource managers during their annual assessment and at least one other monitoring visit. For clients who receive nurse delegation services, the need for which is identified by the DDA assessment, a registered nurse delegator must visit the participant at least once every 90 days. Providers of residential habilitation also receive monitoring visits from state licensers or certifiers who review medication management practices, interview participants and staff, and verify compliance with health and safety regulations and best practices, in addition to monitoring from case resource managers, registered nurse delegators and nursing care consultants. All DDA parties who detect potentially harmful practices are required to report issues utilizing the incident reporting application and conduct appropriate follow-up. Licensers and certifiers utilize their own RCS Residential Quality Assurance Database to document issues of concern, statements of deficiency, corrective action plans and follow up monitoring. RCS data and reports are shared with DDA on a continuous basis.

When an individual is not receiving services from a DDA residential program the individual, her/his/their representatives, her/his/their healthcare provider and DDA work together to monitor medication management. Medication management is a component of the DDA assessment. The DDA assessment triggers a referral requirement if medication risk factors are identified. Once this requirement is triggered the case resource manager must address the risk identified in the PCSP. How the risks are addressed depends on the concern identified. It could result in a medication evaluation referral, additional provider training, nurse oversight visits, consultation with the healthcare provider or other measures.
DDA policy 5.16, Psychotropic Medications establishes guidelines for assisting an individual with mental health issues or persistent challenging behavior to access accurate information about psychotropic medications and treatment, to make fully informed choices, and to be monitored for potential side effects of psychoactive medications.
Protections against the use of chemical restraints are included in DDA Policies 5.14, Positive Behavior Support Principles, Policy 5.15, Restrictive Procedures, Policy 5.16, Psychotropic Medications, Policy 5.19, Positive Behavior Support for Children and Youth, and Policy 6.19, Residential Medication Management with respect to the use of psychotropic medications. If psychotropic medications are used, informed consent must be obtained, a functional assessment must be completed, a positive behavior support plan must be developed and implemented, and a Psychotropic Medication Treatment Plan must be in place. Psychotropic medications can only be used as prescribed.
Additionally, Policy 6.19 Residential Medication Management applies to individuals who receive services from a DDA certified residential program.
Policy 6.19 Residential Medication Management:
When providing instruction and support services to persons with developmental disabilities, the provider must ensure that individuals who use medications are supported in a manner that safeguards the person's health and safety.
For adult residential care facilities, medication management requirements as described in Chapter 388-78A WAC (Assisted living facility licensing rules) take precedence over this policy.
PROCEDURES
A. Self-Administration of Medications
1. Residential service providers must have a written policy, approved by DDA, regarding supervision of self-medication.
2. The provider, unless he or she is a licensed health professional or has been authorized and trained to perform a specifically delegated nursing task, may only assist the person to take medications.
3. The provider may administer the person's medication if he/she/they is a licensed health care professional. Medications may only be administered under the order of a physician or a health care professional with prescriptive authority.
4. If a person requires assistance with the use of medication beyond that described in A.2. above, the assistance must be provided either by a licensed health care professional or a registered nurse (RN) who delegates the administration of the medication according to Chapter 388-101 WAC (Certified community residential services and supports) and Chapter 246-840 WAC (Practical and registered nursing).

Per Chapter 246-840 WAC (Practical and registered nursing), before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: Assess, Plan, Implement, Evaluate. (Please see WAC 246-840-910 through 990 concerning delegation of nursing care tasks in community-based and in-home care settings for specific details.)
Per WAC 246-841-400 (Standards of practice and competencies for nursing assistants), competencies and standards of practice are statements of skills and knowledge, and are written as descriptions of observable,

measurable behaviors. All competencies are performed under the direction and supervision of a licensed registered nurse or licensed practical nurse as required by RCW 18.88A.030 (Nursing Assistants: Scope of practice-Nursing home employment-Voluntary certification-Rules).
WAC 246-841-405 (Nursing assistant delegation) identifies the certification requirements as stated below.
DDA Policy 6.15 ("Nurse Delegation Services") details eligibility requirements for services (including a stable and predictable client condition), which tasks can and cannot be delegated, training and certification requirements for delegated providers, the referral process, case manager responsibilities and Registered Nurse Delegator responsibilities, and authorization of services.
Training Requirements for Providers Who Perform Delegated Nursing Tasks
Before performing a delegated task, the provider must have completed:
1. Registration or certification as a Nursing Assistant and renew annually;
2. The Nurse Delegation for Nursing Assistants class (nine hours), either the classroom or self-study version;
3. For Nursing Assistant-Registered (NAR) only:
a. For providers working in Supported Living: DDA Core Training (32 hours).
b. For providers working in all other settings: Fundamentals of Caregiving (28 hours).
c. An NAR may not perform a delegated task before DDA Core Training or Fundamentals of Caregiving is completed.
d. DDA Core Training or Fundamentals of Caregiving is not required for a Nursing Assistant-Certified (NAC) to perform a delegated task.

Responsibilities of the Registered Nurse Delegator (RND)
The RND must:
1. Verify that the caregiver:
a. Has met training and registration requirements;
b. The registration is current and without restriction; and
c. The caregiver is competent to perform the delegated task.
2. Assess the nursing needs of the individual, determine the appropriateness of delegation in the specific situation and, if appropriate, teach the caregiver to perform the nursing task.
3. Monitor the caregiver’s performance and continued appropriateness of the delegated task.
4. Communicate the results of the nurse delegation assessment to the CRM.
5. Establish a communication plan with the CRM as follows:
a. Specify in the plan how often and when the RND will communicate with the CRM; and
b. Document the plan and all ongoing related communication in the client’s nurse delegation file.
6. Document and perform all delegation activities as required by law, rule and policy.
7. Work with the CRM, providers, and interested parties when rescinding RND to develop an alternative plan that ensures continuity for the provision of the delegated task.

Nurse delegation is an intermittent service. The nurse is required to visit at least once every ninety days, and may not need to see an individual more frequently. However, the delegating nurse may determine that some individuals need to be seen more often. The ALTSA/DDA Central Office Nurse Delegation Program Manager will monitor the nurse's performance, including frequency of visits and payments.

In residential settings, providers are required to document all medication administration and client refusals (of medication).
WAC 388-101D-0340 ("Medications--Documentation") indicates the service provider must maintain a written record of all medications administered to, assisted with, monitored, or refused by the individual.
WAC 388-101D-0325 ("Medication Refusal") indicates
(1) When an individual who is receiving medication support from the service provider chooses to not take his/her/their medications, the service provider must:
(a) Respect the client's right to choose not to take the medication(s) including psychoactive medication(s); and
(b) Document the time, date and medication the individual did not take.
(2) The service provider must take the appropriate action, including notifying the prescriber or primary care practitioner, when the individual chooses to not take his/her/their medications and the refusal could cause harm to the individual or others.

Any person may call the Nurse Delegation Hotline at (800)422-3263 to file a complaint.
References:

-DDA Policy 5.14: Positive Behavior Support Principles
-DDA Policy 5.15: Restrictive Procedures
-DDA Policy 5.16: Psychotropic Medications
-DDA Policy 5.19: Positive Behavior Support for Children and Youth
-DDA Policy 6.15 Nurse Delegation Services
-DDA Policy 6.19 Residential Medication Management
-RCW 18.88A.030 Nursing Assistants: Scope of practice-Nursing home employment-Voluntary certification-Rules
-Chapter 246-840 WAC Practical and registered nursing
-WAC 246-841-400 Standards of practice and competencies for nursing assistants
-WAC 246-841-405 Nursing assistant delegation
-WAC 388-101D-0325 Medication refusal
-WAC 388-101D-0340 Medications-documentation

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Department of Social and Health Services:
- Developmental Disabilities Administration (DDA)
- Aging and Long-Term Support Administration/Residential Care Services (RCS)
- Aging and Long-Term Support Administration/Adult Protective Services (APS)

The Department of Children, Youth and Families:
- Child Protective Services (CPS)

DDA Policy 5.16, Psychotropic Medications, details monitoring requirements for all residential service providers. Policy 5.16 directs the service provider to monitor the client to help determine if the medication is being effective based on criteria identified in the Psychotropic Medication Treatment Plan (PMTP). If the medication does not appear to have the desired effects, the service provider must communicate this to the prescribing professional. The PMTP must include: a) A description of the behaviors, symptoms or conditions for which the medication is prescribed and a mental health diagnosis, if available; b) The name, dosage, and frequency of the medication (subsequent changes in dosage may be documented in the person's medical record); c) The length of time considered sufficient to determine if the medication is effective (i.e. , treatment trial); d) The behavioral criteria to determine whether the medication is effective (i.e., what changes in behavior, mood, thought, or functioning are considered evidence that the medication is effective); and e) The anticipated schedule of visits with the prescribing professional. The service provider must observe the client for any changes in behavior or health that might be side effects of the medication and inform the prescribing professional of any concerns. The service provider should request that the prescribing professional see the client at least every three months unless the prescribing professional recommends a different schedule. Continued need for the medication and possible reduction should be assessed at least annual by the prescribing professional.

Residential Care Services (RCS) certifiers review all medication management as part of their certification process not less than once every eighteen months. In addition, DDA Residential Quality Assurance staff make follow-up visits following any citations issues to service providers. Nurse delegators also provide follow-up visits to participants with nurse delegated tasks on a regular basis.
DCYF/DLR (Division of Licensed Resources within The Department of Children, Youth and Families) is responsible for monitoring medication administration as a part of overall performance monitoring in licensed residential settings for children. The Department of Children, Youth and Families Management Information System (CAMIS) database containing the record of licensing inspections and required provider training is maintained and monitored by The Department of Children, Youth and Families /Division of Licensed Resources (DLR). As part of the ongoing performance monitoring, a schedule of unannounced visits is established for all Foster Home and Staffed Residential providers. The licensed providers are reviewed at least every 36 months to assess performance against ongoing licensing requirements. The schedule is continually monitored and updated by DLR for compliance. Outcomes of the licensing process, such as statements of deficiency and corrective actions, are documented in the database and are used to determine whether or not licensure will continue or establish the frequency of unannounced visits. Communication regarding the licensing process occurs at the regional level.
DDA Policy 6.19, Residential Medication Management (see G-3-b-i) specifies the requirements for residential medication management. Residential Care Services has contracted evaluators who evaluate the residential agencies/programs at least once every two years.

Issues with medication management are also identified if errors result in allegations of abuse, neglect, exploitation. Under authority provided via RCW 74.34 (public assistance Washington state law concerning abuse of vulnerable adults), the Aging and Long-Term Support Administration (ALTSA) receives reports and conducts investigations of abuse, neglect, and exploitation for individuals enrolled with the Developmental Disabilities Administration. ALTSA's Residential Care Services (RCS) investigates provider systemic issues regarding abuse and neglect occurring in nursing homes, adult residential care facilities, adult family homes, & supported living programs. ALTSA's Adult Protective Services (APS) investigates the perpetrators of abuse and neglect involving adults.
Under authority provided via RCW 26.44 (Washington state law concerning abuse of children), Child Protective Services (CPS) investigates all allegations of abuse, neglect, and exploitation of children living in their parents' home and/or licensed facility or foster care. Substantiations are forwarded to the BCCU.
CPS, RCS and APS are using TIVA (Tracking Incidents for Vulnerable Adults) and FamLink (DCYF's case management system) to document investigation activities including intake of complaints and outcome reports. There is an electronic connection between TIVA/FamLink and the CARE system to notify case managers of a)

complaints that are referred for investigations and b) investigation outcomes. This is an electronic notification that will be included in the individual's CARE record.
ALTSA receives nightly data feeds from FamLink that are used in this ALTSA reporting system. FamLink information is reviewed to determine if client information matches DDA waiver participants who are identified in CARE. DDA uses the ALTSA reporting system to address specific programmatic and provider issues from the outcomes of the waiver participants who were involved in investigations by Residential Care Services (RCS) and/or Child Protective Services (CPS) for whom a report of abuse, neglect, abandonment, or financial exploitation was substantiated. The data are broken out by type of incident and provider type.

Information and findings are communicated to the Medicaid agency at least quarterly via the HCA Medicaid Agency Waiver Management Committee.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDA Administration Policy 6.19, Residential Medication Management specifies the requirements for residential medication management. Residential Care Services (RCS) has contracted staff who evaluate the residential agencies/programs at least once every two years to ensure they are in compliance with these requirements.

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  The Developmental Disabilities Administration (DDA) within the Department of Social and Health Services (DSHS).

  (b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record all medication errors.

WAC 388-101D-0340 ("Medications--Documentation") indicates the service provider must maintain a written record of all medications administered to, assisted with, monitored, or refused by the individual.
WAC 388-101D-0325 ("Medication Refusal") indicates
(1) When an individual who is receiving medication support from the service provider chooses to not take his/her/their medications, the service provider must:
(a) Respect the individual's right to choose not to take the medication(s) including psychotropic medication(s); and
(b) Document the time, date and medication the individual did not take.
(2) The service provider must take the appropriate action, including notifying the prescriber or primary care practitioner, when the individual chooses to not take his/her/their medications and the individual's refusal could cause harm to the individual or others.

(c) Specify the types of medication errors that providers must *report* to the state:

Providers are required to report medication errors causing injury/harm, or a pattern of errors.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The following State agencies all generate data concerning medication management:
The Department of Social and Health Services:
- Developmental Disabilities Administration (DDA)
- Aging and Long-Term Support Administration/Residential Care Services (RCS)

The Department of Children, Youth and Families:
- Child Protective Services (CPS)

DDA quality assurance staff acquire data from all of these sources, analyze data to identify trends and patterns and identify areas for improvement. Quality assurance staff share this analysis, identified trends and patterns and recommend areas for improvement to senior management on a quarterly basis.
DDA Policy 6.19, Residential Medication Management, (please see G-3-b-i) specifies the requirements for residential medication management. RCS has contracted staff who evaluate the residential agencies/programs at least once every two years. RCS data on residential agency performance is share with DDA quality assurance staff on a continuous basis.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.1. # & % of incidents alleging abuse, neglect, exploitation, abandonment or unexplained death (ANEAUD) of waiver participants reported by DDA, per policy, to APS, CPS, or RCS. N = # of incidents alleging ANEAUD of waiver participants reported by DDA, per policy, to APS, CPS, or RCS. D = All allegations of ANEAUD requiring notification by DDA, per policy, to APS, CPS, or RCS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA's Incident Reporting Application

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.5 # & % of waiver participants signing their annual PCSPs who report they have received information on how to identify & report instances of abuse, neglect, exploitation & unexplained deaths (ANED). N = # of waiver participants signing their annual PCSPs who report they have received information on how to identify & report instances of ANED. D = # of waiver participants' annual PCSPs.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CARE system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
G.a.4. # & % of respondents to NCI Survey who report they have received information on how to identify and report instances of abuse, neglect, exploitation and unexplained deaths. N = # of respondents to NCI Survey who report they have received information on how to identify and report instances of abuse, neglect, exploitation and unexplained deaths. D = # of respondents to NCI Survey reviewed.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
NCI Survey

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.2: # & % of incidents alleging abuse, neglect, exploitation, abandonment or unexplained death (ANEAUD) where waiver participant &/or legal rep was contacted within 30 days to ensure safety plans were implemented. N = # of incidents alleging ANEAUD where waiver part &/or legal rep was contacted within 30 days to ensure safety plans were implemented. D = # of incidents of alleged ANEAUD.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA's Incident Reporting Application

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
G.a.6: # & % of Medicaid claims for hospital admissions & ER (MCHAER) visits meeting policy 12.01 criteria for incident reporting (IR) that are reported for wvr parts receiving residential habilitation. N: # of MCHAER visits meeting policy 12.01 criteria for IR that are reported for wvr parts receiving res hab. D: # of MCHAER meeting policy 12.01 criteria for clients receiving res hab reviewed.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.7. - The number and percent of unexpected deaths that were reported to DDA on time by waiver Residential Habilitation providers according to policy. N: Number of unexpected deaths that were reported to DDA on time by waiver Residential Habilitation providers according to policy. D: Total number of unexpected deaths in waiver Residential Habilitation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA Incident Report System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
G.b.2. # & % waiver participants with 4 or more similar incident reports (IRs) during calendar quarter reviewed by QA staff to verify required health & welfare actions were taken. N = # wvr part with 4 or more similar IRs during calendar qrtr reviewed by QA staff to verify required health & welfare actions were taken. D = All wvr part with 4 or more similar IRs during calendar qrtr.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA's Incident Reporting Application

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.b.3 The number and percent of mortality review trends where systemic interventions were implemented. N = The number of mortality review trends where systemic interventions were implemented. D = The number of mortality review trends where systemic interventions were necessary.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.b.1. The number & percent of critical incident trends where systemic interventions were implemented. N = The number of critical incident trends where systemic interventions were implemented. D = Number of critical incident trends.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA's Incident Reporting Application

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G.c.1 # & % incidents for waiver participants involving improper use of restraints or

restrictive procedure that received appropriate follow-up. N = # incidents for waiver participants involving improper use of restraints or restrictive procedure that received appropriate follow-up. D = Total incidents for wvr participants involving improper use of restraints or restrictive procedures reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
RCS Residential Quality Assurance Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Residential Care Services/ALTSA/DSHS	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.c.3: # & % of waiver participants whose PCSPs documented restraints or restrictions that were utilized in compliance with DDA policies & waiver requirements. N= # of waiver participants whose PCSPs documented restraints or restrictions that were utilized in compliance with DDA policies & waiver requirements. D = # of waiver participants whose PCSP documented restraints or restrictions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Assessment Reporting and Evaluation (CARE) system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.c.2: Number & percent of citations in statements of deficiency that don't involve repeat citations of restrictive procedure by residential providers. N = The number of citations in statement of deficiency that don't involve repeat citations of restrictive

procedures by residential providers. D = All citations in statements of deficiency for residential providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
RCS Residential Quality Assurance Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Residential Care Services/ALTSA/DSHS	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.c.4: Number and percent of waiver residential habilitation providers with policies and procedures in place that prohibit the use of seclusion. N = Number of waiver residential habilitation providers with policies and procedures in place that prohibit the use of seclusion. D = All waiver residential habilitation providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% Confidence Interval with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G.d.3: The number and percent of citations in statements of deficiency that don't involve client healthcare standards by residential providers. Numerator= The number of citations in statements of deficiency that don't involve client healthcare standards by residential providers. Denominator = All citations in statements of deficiency for residential providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
RCS Residential Quality Assurance Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Residential Care Services/ALTSA/DSHS	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.d.1. # & % of waiver participants who visited the dentist during the year or whose CRM documented a discussion concerning the importance of annual dental care. N = Number of waiver participants who visited the dentist during the year or whose CRM documented a discussion concerning the importance of annual dental care. D = All waiver participants' records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA's Comprehensive Assessment Reporting and Evaluation (CARE) system

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.d.5 # & % of systemic interventions implemented in residential habilitation when 3 most frequently cited health & welfare regulation violations occurred. N = # of systemic interventions that were implemented in res hab when 3 most frequently cited health & welfare regulation violations occurred. D = 3 most frequently cited health & welfare regulation violations in res hab reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
RCS data and Residential Quality Assurance Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.d.2. Number and percent of waiver participants who rate their health as "poor" and who visited a doctor within the past 12 months. N = Number of waiver participants who rate their health as "poor" and who visited a doctor within the past 12 months. D = All waiver participants who rate their health as "poor."

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Assessment Reporting and Evaluation (CARE) system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
G.d.4: # & % of licensed/certified waiver service providers who met state & waiver training requirements as verified by state policies & procedures (P&P). N = # of licensed/certified wvr svs providers who met state & waiver training requirements as verified by state (P&P). D = All licensed/certified wvr svs providers requiring licensure/certification & state & waiver training that were reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
RCS Residential Quality Assurance Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: Residential Care Services/ALTSA/DSHS	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

QIP for Performance Measure G.a.2 is located at Main B. Optional

G.a.1; G.a.2; G.a.6; G.b.1;G.b.2: Alleged incidents of abuse, neglect, abandonment and exploitation are recorded in the DDA Incident Reporting (IR) Application. The application also documents contacts and follow-up referrals. A report is compiled based on incident type and other agencies contacted to document whether or not APS, CPS, or RCS was notified. Trending of incident types, actions taken, incident trends, use of restraints & compliance with DDA policies are generated from incident reporting data.

G.a.7; G.b.3: The Mortality Review Team (MRT) reviews waiver recipients whose death occurred while receiving residential services, medically intensive children's program services or whose death was unusual or unexplained to identify factors that may have contributed to the deaths and to recommend measures to improve client supports and services.

G.a.4: NCI Surveys record waiver participants knowledge of how to report abuse, neglect, exploitation and unexplained deaths.

G.a.5: The State utilizes the NCI Survey to gauge how well participants report that they have received information on how to identify and report incidents of abuse, neglect, exploitation & unexplained deaths. The State also collaborates with the DDC, the ARC of Washington and other partner agencies to educate waiver participants via webinars, websites and direct-to-participant communications on the ways to report incidents to the state.

G.c.1, G.c.2, G.d.3 and G.d.4: RCS conducts onsite visits to review the restrictive procedures and areas involving clients' healthcare standards at residential sites throughout the state. RCS issues the citations for concerned areas accordingly and providers are required to submit and implement the approved corrective action plan within expected timelines. Visit data is maintained in RCS's Residential Quality Assurance Database and reports are shared with DDA's Residential Quality Assurance staff.

G.c.3, G.d.1 & G.d.2: Information on documented restraints or restrictions, health rating and doctor/dentist visits for all waiver participants is obtained as a required set of questions in the DDA annual assessment and reports are available as data extracts from the CARE system.

G.c.4 Annual survey of waiver residential habilitation providers, re-contracting of residential habilitation providers, and certification reviews offer opportunities to verify, review and suggest updates to policies and procedures that prohibit the use of seclusion.

G.d.5. State will review quarterly the most serious cited regulation violations related to participant health and welfare in residential habilitation to focus systemic interventions on highest value changes.

b. Methods for Remediation/Fixing Individual Problems

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

G.a.1; G.a.2; G.a.6; G.b.1;G.b.2;G.c.1: If a pattern of critical incidents is identified with respect to a specific individual or a specific provider, or a particular type of incident, the Quality Assurance Office Chief works with the appropriate HQ and/or regional staff to take appropriate steps to prevent future occurrences of such incidents. In addition, case resource manager training might focus on prevention, detection, and remediation of critical incidents.

G.a.2: If following notification of an incident the waiver participant/legal representative was not contacted within 30 days, the supervisor and case resource manager are reminded that this is required. If no contact was made at all, follow-up with the waiver participant/legal representative is required.

G.a.7, G.b.3: Changes implemented as a result of information gained from MRT reviews include caregiver alerts, curriculum for providers and case resource managers, and changes in DSHS administrative rules (WAC). For example, topics of caregiver alerts include "How hot is your water?", "Aspiration", "Seizures and Bathing", and "Type 2 Diabetes".

G.a.4, G.a.5 – Management annually reviews analysis of NCI survey results and implements necessary changes in policy, procedures or training to improve results. NCI survey results are a component of the comprehensive annual QIS which documents any necessary remediation.

G.c.3 – Management annually reviews analysis of CARE data and implements necessary changes in policy, procedures or training to improve results. CARE data are a component of the comprehensive annual QIS which documents any necessary remediation.

G.b.1: QA Managers will review incident trends on a quarterly basis and determine the need for systematic interventions.

G.c.1, G.c.2, G.d.3 and G.d.4: RCS follows up on the citations/corrective action plan implementation within 60 days. DDA also reviews the RCS citations and providers' corrective action plans and conducts onsite visits within 120 days to review the restrictive procedures and other concerned areas involving clients' healthcare standards.

G.c.1, G.c.4 The state responds to citations in statements of deficiency in the following order:

- Once RCS issues the citations in statements of deficiency to the residential providers based on audit findings, residential providers submit their corrective action plans to RCS within 10 days of receiving the statements of deficiency.
- RCS and DDA reviews the providers' corrective action and makes appropriate recommendations to ensure the ongoing compliance with the identified issues. RCS conducts onsite visit within first 90 days of approving the providers' corrective plan to ensure the proper implementation of each steps identified in the corrective action plans.
- DDA reviews RCS visit details and make on-site visits within first 120 days of approving the corrective action plans to ensure that necessary steps are being taken and implemented by residential providers to ensure the on-going compliance in identified areas.
- DDA also provides:
  - o Consultation
  - o Training
  - o Technical Assistance and Support
  - o Additional Oversight

G.c.2 RCS issues citations in statements of deficiency for repeat citations. Depending upon the severity of the findings, RCS reviews may lead to disciplinary actions including up to decertification of residential providers with the state. DDA reviews for repeat citations of each residential provider and offers consultation, training, technical assistance and support to assist providers as required. If the provider is still unable to implement the necessary program changes, DDA will terminate the contract.

G.d.1. and G.d.2: For those with a health rating of "poor" who have not visited a doctor and those who haven't had a visit with a dentist within the past 12 months, case resource managers will discuss with waiver participants (and their families) the importance of visiting their doctor and dentist at least annually.

G.d.5 – Management reviews quarterly analysis of regulation violations in residential habilitation settings and focuses remediation on three most serious types of health and welfare regulation violations.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Developmental Disabilities Administration (DDA) has managed at least one HCBS waiver since 1983. In 2003 a statewide effort was launched to coordinate the implementation of Quality Improvement in all agencies. We have developed multiple processes for trending, prioritizing, and implementing system improvements that have been prompted as a result of data analysis.

Internal DDA Systems
DDA uses several data systems that are vital to the implementation of the Waiver.

DDA Assessment:
o The DDA Assessment is designed to discover the individual support needs of each individual who is assessed. It is a tool to help case resource managers plan for services and supports to meet the needs of individuals with developmental disabilities.
o All Waiver participants will be assessed using this tool, which includes an assessment of caregiver stress, behavior issues, critical medical issues, and protective supervision needs.
• Data is pulled as needed by program managers, waiver services unit manager, quality assurance staff and management.
• Data is analyzed by the appropriate entity who is using the information for system improvement activities.

Comprehensive Assessment Reporting and Evaluation (CARE):
o Assists case resource managers to provide effective monitoring of case status and service plans.
o Provides a system of ticklers or alerts to cue case resource manager action at specific intervals based upon client need.
o Provides an automated process for Exception to Rule (ETR), Prior Approvals and Waiver Requests.
o Delivers a consistent, reliable and automated process.
o Provides client demographic and waiver status in real time.
o Provides management reports to look for trends and patterns in the Waiver caseload.
• Data is pulled as needed by program managers, regional staff, quality assurance staff and management.
• Data is analyzed by the appropriate entity who is using the information for system improvement activities.

Quality Compliance Coordinator (QCC) Review database:
o Is used to collect review data to insure that the processes and procedures required in delivering waiver services are according to requirements.
o Is used to develop regional and statewide corrective action plans.
• Data is developed by the Office of Compliance, Monitoring and Training.
• Reports are created at least annually.
• Data is analyzed by DDA staff at a minimum annually.

DDA Incident Reporting system (IR):
o The IR system provides management information concerning significant incidents occurring in our client's lives.
o Individual incidents come first to the CRM for input into the IR system.
o DDA has developed protocols and procedures to respond to incidents that have been reported.
o Analysis processes are in place to review and monitor the health and welfare of DDA clients.
• Data is pulled by the Incident Management Program Manager.
• Data is pulled three times a year.
• Data is analyzed by the Incident Reporting Team and as requested by DDA management.

Person-Centered Service Plan Meeting Survey:
o A PCSP Meeting survey is mailed to waiver participants within one month of the PCSP planning meeting. This survey gives participants an opportunity to respond to a series of questions about the PCSP process. The survey is mailed from Central Office based on a random sample across all waivers with a 95% confidence level with a margin of error of +/-5%.
Information collected is analyzed annually by DDA staff.
o Information regarding trends or patterns that is gathered from that data is acted upon, through additional training for case resource managers, clarification of information for participants, etc.
• Data is pulled by the Research and Analysis Program Manager.
• Data is pulled at least annually.

• Data is analyzed by DDA staff at a minimum annually.

Complaint Data Base:
o DDA maintains a Complaint data base that is the repository for complaints that rise above the standard issues that case resource managers or supervisors handle each day as a normal business practice.
• Data is pulled by the Research and Analysis Program Manager.
• Data is pulled at least annually.
• Data is analyzed by DDA staff at a minimum annually.

DSHS systems external to DDA:

ProviderOne and Individual ProviderOne/Health Care Authority:
o DDA audits information from this system to verify services identified in the Person-Centered Service Plan as necessary to meet health and welfare needs have been authorized.
o DDA also audits information from this system to ensure that services are only authorized after first being identified in the Person-Centered Service Plan.
• Data is pulled by the ProviderOne Program Manager.
• Data is pulled at least annually.
• Data is analyzed by DDA staff at a minimum annually.

Child Protective Services (CPS)/Department of Children, Youth and Families:
o CPS is responsible for investigating and making official findings on any accusations of abuse or neglect of a minor child.
o DDA refers all such incidents to CPS for investigation and works cooperatively with them to provide information about the incident and to protect the child during the investigation.
• Data is pulled by the Research and Analysis Program Manager.
• Data is pulled at the request of the Program Manager.
• Data is analyzed by DDA staff at a minimum annually.

Adult Protective Services (APS)/Aging and Long-Term Supports Administration:
o APS is responsible for investigating and making official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult, who does not live in either a licensed setting or is served by a certified residential service.
o DDA refers all such incidents to them for investigation and works cooperatively with them to provide information about the incident and to protect the adult during the investigation.
• Data is pulled by the Research and Analysis Program Manager.
• Data is pulled at least annually.
• Data is analyzed by the Regional Quality Assurance Managers and as requested by DDA management.

Division of Licensing Resources (DLR)/Department of Children, Youth and Families:
o Monitors and licenses Children's Foster Homes, Group Homes and Staffed Residential Homes, which are utilized as respite resources in the waiver program.
o DDA works cooperatively with DLR to ensure homes are licensed and appropriate care is provided.
• Data is pulled by DLR.
• Data is pulled at the request of the Program Manager.
• Data is analyzed by the Program Manager and as requested by management.

Residential Care Services (RCS)/Aging and Long-Term Supports Administration:
o RCS is responsible for investigating provider practices in instances of abuse, neglect or exploitation of a vulnerable adult who receives services from either a licensed setting or is served by a certified residential agency.
o DDA refers incidents to them for investigation and works cooperatively with them to provide information about the incident.
• Data is pulled by the DDA Incident Management Program Manager.
• Data is pulled at least annually.
• Data is analyzed by DDA staff at a minimum annually.

FamLink/TIVA are electronic systems that maintains notifications, investigative and outcome information for CPS, APS and RCS. Data from FAMLINK/TIVA is used to track and trend information related to allegations of abuse, neglect, abandonment and financial exploitation.

Administrative Hearing Data Base:
o The Administrative Hearings data base tracks requests for administrative hearings requested by waiver clients who disagree with decisions made by DDA.
o DDA uses data from this data base to review the concerns of persons on the waivers and determine if there are system issues that need to be addressed.
• Data is pulled by the Research and Analysis Program Manager.
• Data is pulled at least annually.
• Data is analyzed by DDA staff and as requested by DDA management.

Agency Contracts Database (ACD):
o The ACD is an important tool in assuring that waiver service providers have contracts in place that meet requirements.
o The tool is used by DSHS to monitor all state contracts.
o The system monitors compliance with background check requirements, training requirements, evidence of any required licensure, and timeliness of contracts.
• Data is pulled at least annually by the Contracts Program Manager.
• Data is analyzed by DDA staff and as requested by DDA management.

External Non Governmental Systems:

National Core Indicators (NCI) Survey:
o DDA has been participating in the NCI Survey since 2000.
o DDA has adapted the survey to do a face-to-face survey in the home that addresses satisfaction with DDA services, providers and other key life indicators.
o Additional questions have been added about waiver services.
o This data is reviewed with stakeholders and state staff.
• Data is pulled at least annually by the Research and Analysis Program Manager.
• Data is analyzed by DDA staff and as requested by DDA management.
• Recommendations for needed changes are developed from this process and necessary action is taken.

Developmental Disabilities Council (DDC):
o The DDC partners with the state to conduct focus groups that look at the NCI data and make recommendations to the state.
o Reports are developed by the DDC and submitted to the state for action.
• Reports are delivered to DDA upon completion.
• DDA responds with appropriate action.

Information from the above data systems is gathered and analyzed in order to continually monitor and make changes to our delivery system when the need is demonstrated. DDA utilizes a variety of methods to analyze data. Some examples include identifying trigger points that require more in-depth analysis using control charts and other types of analysis; or in-depth work focused on the occurrence of a serious incident.

Once the need for change has been determined through the analysis of data, DDA prioritizes quality improvement steps based on a risk management strategy that considers health and safety, best practices, legislative requirements, and CMS recommendations.

DDA then implements needed system improvements through a variety of methods, such as training and re-training; resource allocation; studies; policy or rule changes; and funding requests. DDA identifies who is responsible for implementation of the needed change, how that will be accomplished and timelines for accomplishing the needed change.

Strategies for improvement are specific to the type of improvement that is indicated by the data that has been reviewed. However the process is generally the same:

1. We review and analyze data;
2. We strategize to find solutions to any problems identified from the data;
3. Action plans are developed; and
4. Progress is reviewed until goals are accomplished.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☒ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: 2 times per year. 3 times per year. 6 times per year during the first year of the biennium.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Developmental Disabilities Administration (DDA) uses a discovery and monitoring process to analyze the effectiveness of our current systems. All collected data is identified by waiver type in order to evaluate and monitor each individualized waiver program. Performance is measured in terms of outcomes. DDA uses both internal and external groups to analyze this data. DDA reviews data from multiple data sources to discover whether trends and patterns meet expected outcomes. DDA begins an improvement process if they do not. DDA's Quality Improvement (QI) process has been part of the Administration's activities for decades.

The goal of Quality Improvement in DDA is to promote, encourage, empower and support continuous quality improvement. Major areas of focus:

Surveys
- PCSP surveys give individuals/guardians an opportunity to provide anonymous feedback on the planning process. Information collected from these surveys is used to analyze the effectiveness of the planning process.

Reviews
- Reviews ensure that processes and procedures required in delivering waiver services are according to requirements.
- Waiver review findings are analyzed and shared with regional and statewide management teams for corrective action and system improvement.

Quarterly evaluations of performance measures
- Quarterly DDA Regional management reports on waiver performance.
- The report contains data such as the number of waiver assessments due with respect to the number that were completed, the regional progress on correction related to QCC audit findings, and many other key indicators of operational performance.

Training
- Training is a significant focus to ensure that administration employees are equipped with the skills and knowledge to carry out their waiver responsibilities.
- Annual Waiver training is provided for ongoing improvement.

There are many entities that play a critical role and are essential to DDA's Quality Management Strategy:

Internal (within DSHS)

Incident Review Team (IRT):
- This team meets monthly to review aggregate data from the Electronic Incident Reporting System and make recommendations to prevent incidents.
- Team members include:
  - Waiver Program Managers (PM), Waiver Requirements PM, RHC PM, Incident Management PM, Mental Health PM, County Services Unit Manager, Quality Assurance PM, Compliance, Monitoring and Training Office Chief, Medicaid and Eligibility Office Chief, Statewide Investigation Unit Manager and Data Analyst for RHC investigation unit.

Mortality Review Team (MRT):
- Meets monthly to review deaths of participants and monitor and make recommendations on trends and patterns.
- Team members are:
  - RHC PM, Mental Health PM, Residential PMs, Compliance Monitoring and Training Office Chief, Medicaid and Eligibility Office Chief, Waiver Services Unit Manager, Statewide Investigation Unit Manager, Nursing Services Unit Manager and PASRR and RHC Quality Management Systems Unit Manager.

Nursing Care Consultants (NCC):
- Assigned to Regions to review and monitor health and safety concerns.
- Nurses consult with case resource managers on health and welfare concerns.

Waiver Services Unit Manager and Regional Waiver Specialists:
• The primary responsibility for the implementation of this waiver resides with the Waiver Services Unit Manager and the IFS Program Manager
• Regional Waiver Specialists work collaboratively with the Waiver Service Unit Manager and IFS Program Manager to ensure proper implementation at the regional level.
• The Waiver Services Unit Manager and Waiver Specialists meet every other month to monitor waiver implementation and recommend necessary waiver changes.

Regional Quality Assurance (QA) staff:
• Provide quarterly reports which contain quality assurance information on incidents and other QA activities in the region.

Department of Children, Youth and Families:
• Division of Licensing Resources(DLR) monitors and licenses Children's Foster Homes, Group Homes and Staffed Residential Homes.
• Child Protective Services (CPS) provides investigation of incidents of abuse, neglect, abandonment and exploitation involving children.

External

Medicaid Agency Waiver Management Committee:
• This committee meets four times per year and is comprised of representatives from the Health Care Authority (the single State Medicaid Agency), Home and Community Services. the Behavioral Health Administration, and the Developmental Disabilities Administration.
• The Committee presents information to the single State Medicaid Agency in the following areas:
o Annual reports from the three administrations
o QCC reviews
o National Core Indicators
o Fiscal reports

The HCA provides recommendations and feedback based on the information provided.

Stakeholder input and review of waiver programs:
• A web site offers stakeholders an opportunity to:
o Review annual reports.
o Review quality assurance activities.
o Provide suggestions for ways to better serve waiver clients.

Developmental Disabilities Council (DDC):
• The DDC is comprised of self-advocates, family members and department representatives.
o The DDC analyzes and provides recommendations for improvement using the National Core Indicators Survey as its' tool.

The HCBS (DDA) Waivers Quality Assurance Committee:
• Sponsored by the DDC and comprised of self-advocates, family members, providers and Department representatives.
o Meets four times a year, with provision for more frequent sub-committee meetings on select topics as needed.
o Provides a forum for active, open and continuous dialogue between stakeholders and the DDA for implementing, monitoring and improving the delivery of waiver services to best meet the needs of people with intellectual and developmental disabilities.

The Medicaid Agency Waiver Management Committee:
• Includes representatives from the Health Care Authority (the single State Medicaid Agency) and Administrations/Divisions within the operating agency: DDA, HCS, RCS, and BHA. The committee meets quarterly to review
all functions delegated to the operating agency, current quality assurance activity, pending waiver activity

(e.g., amendments, renewals), potential waiver policy and rule changes and quality improvement activities.

Various reports are disseminated to both external and internal groups. These groups are involved in evaluating the performance and progress of the Waiver program. Through this review process these groups also provide feedback on opportunities for improvement.

Included in the distribution cycle are:

Internal:

- DDA Assistant Secretary, HQ Management Team and Regional Management Team reviews:
  - Quarterly Regional management reports on the waiver performance.
  - The report contains data such as the number of waiver assessments due against the number that were completed, the regional progress on correction related to QCC review findings, and many other key indicators of operational performance.

- DDA Assistant Secretary, HQ Management Team and all Regional Management Teams reviews:
  - The Quarterly Regional Quality Assurance Managers reports are compiled into one final report.
  - Each regional QA report, also in a PowerPoint format contains 8 control charts from the key incident types, a detailed analysis of any client with 3 or more incidents, analysis of deaths, and information/ data on many other QA activities in the region.

  - When the final report is compiled best practices and concerns are reviewed and necessary action is taken.

QCC reviews:
- Statewide analysis of review findings. The report includes data and recommendations from the annual review cycle. This report is then shared with the Medicaid Agency Waiver Management Committee and the Statewide Management Team.
- Regional review findings. The regional reports are specific to the regional review. Each report provides an analysis of the data from the most current review and compares historical data (when available).

DDA Assistant Secretary Reviews:
- Monthly fiscal reports provided by Management Services Division (MSD).
  - These reports provide detailed analysis of the waiver expenditures and clients served.

External

A web site offers stakeholders an opportunity to review:
- Annual waiver progress/performance reports.
- The reports are often PowerPoint presentations with control charts or Pareto charts constructed from data related to performance measures.

Washington State Developmental Disabilities Council (DDC):
- Annual NCI Core Indicator reports are provided to the DDC for their recommendation and feedback.
- The NCI reports focus on participant satisfaction or areas of concern.
- The DDC invites families and self-advocates to review the data from the National Core Indicator survey report. Their feedback and recommendations are then shared with DDA management after every evaluation.

The Medicaid Agency Waiver Management Committee:
- Includes representatives from the Health Care Authority (the Single State Medicaid Agency) and Administrations/Divisions within the operating agency: DDA, HCS, RCS, and BHA.
- Meets at least quarterly to review:
  - All functions delegated to the operating agency
  - Current quality assurance activity
  - Pending waiver activity (e.g., amendments, renewals)
  - Potential waiver policy and rule changes

- Quality improvement activities

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Developmental Disabilities Administration (DDA) believes that the quality of programs and services delivered to people with developmental disabilities in Washington State is everyones business. The evaluation and improvement of processes and systems are ongoing. All collected data is identified by each waiver type in order to evaluate and monitor individualized waiver program effectiveness.

Each year DDA improves services to waiver clients by using the numerous data collection points, appropriate analysis and prioritization techniques, evaluation and feedback from differing groups.

DDA also seeks the assistance of CMS and other entities through grants, conferences, or Best Practices information, to continue to refine benchmarks for improvement and evaluate the system against those benchmarks.

The Quality Improvement Strategy will be re-evaluated at least once during the five year approval period. The following process will be followed in reviewing and updating the Quality Improvement Strategy:
- o DDA will maintain a waiver management strategy.
- o All processes and strategies will be continuously improved through the various methods of evaluation, monitoring, analysis and actions taken.
- o DDA will work with participants, families, advocates, and providers to identify opportunities for performance improvement and report the progress being made back to stakeholders.
- o State staff, providers and stakeholders will provide ongoing monitoring of the system. Changes may be recommended by any of the above entities.

Explanation and Examples of Types of Data Analysis Used:

Charting Data: Using charts and graphs, often provides greater insight and interpretation of data. Data charts provide a powerful tool to help observe and analyze the behavior of processes and the effects of trial solutions. They are the best way to present data to others helping them to quickly grasp the information.

Chart Selection Guide: The information below summarizes several chart types that are useful in Quality Improvement and suggests possible applications:

A pie chart presents data as a percentage of a total. Examples of application include sources of errors and make up of a budget.

A bar chart presents comparisons of data categories. These can be categories at a point in time or changes in categories over a period of time. Examples of application include the number of errors over time, process output by month or by department, and comparison of results using different methods.

Pareto charts present data relative to the size of categories in order. Examples of application include customer quality characteristics in order of importance, and types of customer complaints.

Histo-grams present a distribution of a set of data (how frequently the given values occur) and shows the stability of a process. One example of application is variation of complaint resolution times.

Line charts represent behavior over time, same data collection frequency, and X charts. Examples of application include time to complete inspections over time, and the number of customer complaints over time.

Control charts present the common cause and special cause variation based on 3 sigma of the average, X bar and R, X and mr charts. Examples of application include time to fulfill customer requests, and the number of IRs per month.
Description of common quality assurance system across all five DDA waivers:
In 2014 waiver amendments, CMS approved Washington State’s modification of its sampling design for compiling data on its performance measures from sampling waivers individually to drawing a single sample across all of its DDA HCBS waivers. This language was removed in error from the waiver renewal in 2017 and is replaced here. The DDA HCBS waiver program meets the conditions that are a requirement for the use of this sampling method and will allow a one-year cycle for data collection on performance measures, compared with the

previous two-year cycle necessitated by the larger total sample size.

1. Design of the waivers

The DDA waivers are all very similar in design in that the waivers have many services in common, participant safeguards are common across waivers, and a single quality management and improvement strategy is used for the entire DDA waiver program. In addition, waiver program case management is provided by state employees for all waiver participants and the same assessment is used to develop the person-centered service plan (PCSP).

2.a. Participant Services

Many services are identical across waivers, and the rest are much more similar than different. And oversight of services (e.g., to ensure provider contracts are in place, providers are qualified, services authorized are being provided) is based on the same processes across all waivers.

The following services are covered by all of DDA's current waivers: assistive technology, stabilization services (specialized habilitation, crisis diversion beds, staff/family consultation services), environmental adaptations, risk assessment, specialized equipment and supplies, staff/family consultation services and transportation.

The following services are covered by three or four of the DDA waivers: community engagement, community inclusion, extermination of bed bugs, physical therapy, occupational therapy, speech, hearing and language services, respite, skilled nursing, specialized habilitation, individual supported employment/group supported employment, individualized technical assistance, therapeutic adaptations and wellness education.

Services specific to one or two waivers are community transition, residential habilitation, equine therapy, music therapy, supported parenting services, peer mentoring, person-centered plan facilitation, specialized evaluation and consultation and specialized clothing.

2.b. Participant Safeguards

1. Response to Critical Events or Incidents

Responses to critical events or incidents are not differentiated based on waiver type. Differences in response are based on the setting (e.g., licensed, certified or private residences) and/or the entity responsible for investigating (i.e., Child Protective Services, Adult Protective Services, Residential Care Services). Critical events or incidents must be reported irrespective of the setting or waiver enrollment.

2. Safeguards concerning restraints and restrictive interventions

DDA's extensive protocols concerning the use of restraints and restrictive procedures are not waiver-specific. (Please see Appendix G-2 for an inventory of relevant DDA policies.) In addition, reporting and investigating of abuse and neglect apply to all settings.

2.c. Quality Management Processes and Mechanisms

Critical components of the quality management system include:

- DDA Assessment
- CARE (Comprehensive Assessment Reporting and Evaluation)
- Quality Compliance Coordinator (QCC) Protocols and Data Base
- DDA Incident Reporting System
- Person-Centered Service Plan Meeting Survey
- Complaint Data Base
- Administrative Hearing Data Base
- Agency Contracts Data Base
- National Core Indicators Surveys

3.a. Methodology for discovering information (e.g., data systems, sample selection)

The methodologies for discovering information are common across the entire DDA HCBS waiver program. These methodologies include:

- Quality Compliance Coordinator (QCC) sampling of waiver participant files and file reviews to ensure waiver assurances are being met.
- Person-Centered Service Plan (PCSP) Meeting Survey, which is mailed within one month of the PCSP planning meeting and gives waiver participants an opportunity to respond to a series of questions about the PCSP process.
- National Core Indicators (NCI) Surveys, which includes a standardized set of questions used by all participating states. In addition, WA State has added questions about waiver services. Waiver participants as

well as
parents/guardians receive the survey.
- FAMLINK, which is an electronic system that maintains notifications, investigative, and outcome information for Child Protective Services (CPS). Data from FAMLINK is used to track and trend information related to allegations
of abuse, neglect, abandonment and financial exploitation.
- TIVA (Tracking Investigations of Vulnerable Adults), which is an electronic system that maintains notifications, investigative, and outcome information for the Resident and Client Protection Program (RCPP) in Residential Care
Services (RCS) and Adult Protective Services (APS) investigations. An additional data feed from ProviderOne has also been included to allow TIVA to collect information related to children and adolescents (under age 21 years)
who are receiving mental health services and involved in abuse, neglect, and/or exploitation investigations. Data from TIVA is also used to track and trend information related to allegations of abuse, neglect,
abandonment and financial exploitation.
- Administrative Hearing Data Base, which tracks requests for administrative hearings requested by waiver participants who disagree with decisions made by DDA. DDA uses data from this data base to review the concerns of waiver
participants to determine if there are system issues that need to be addressed.
- Agency Contracts Database (ACD), which is used to monitor provider compliance with contracting requirements, including background check requirements, training requirements, and licensure and certification requirements.
- Mortality Review Team (MRT) Reviews of waiver participant deaths.

3.b. Manner in which individual issues are remedied.
Since all waiver participants have a state-employed Case/Resource Manager or Social Services Specialist, remediation activities typically begin at the case management level. In all cases, the DDA strives to provide waiver participants, families and DDA employees with the tools and information necessary to implement HCBS waivers that successfully support individuals in their communities.
When issues with respect to individual waiver participants are identified, case management staff are notified so that immediate action can be taken to address the issues.
Information from the various data sources described above is analyzed to determine: a) whether issues are systemic or individual, and b) the optimum strategy to address the issues identified.
Strategies to address issues in the DDA HCBS waiver program include:
- Edits in computer-based systems to require necessary information be included or to prevent inappropriate action;
- Additions to or development of computer-based systems to accommodate waiver processes such as person-centered planning and quality improvement activities such as monitoring of waiver participant abuse and neglect;
- Revisions in Washington Administrative Code (WAC) to clarify waiver requirements so that waiver participants, families and DDA staff all understand waiver requirements;
- Revisions or additions to DDA publications that provide waiver participants, guardians and families with up-to-date information on the HCBA waivers available, including the populations served, services covered, how to request
waiver enrollment, and administrative hearing rights and procedures; and
- Revisions or additions to guidance (e.g., staff training, the DDA waiver manual, management bulletins, WAC) provided to DDA case management staff on the waivers and waiver-related processes (e.g., waiver enrollment,
development of the person-centered plan, provision of waiver services, oversight of the individual support plan).

See additional information at Main.B. Optional

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

QIP for Performance Measure-D.d.2- The percentage of waiver PCSPs with services that are delivered within 90 days of the PCSP effective date or as specified in the PCSP.

Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measure D.d.2: The percentage of waiver PCSPs with services that are delivered within 90 days of the PCSP effective date or as specified in the PCSP. Numerator = All waiver PCSPs reviewed with services delivered within 90 days or as specified in the PCSP. Denominator = All waiver PCSPs reviewed.

Current compliance is 82% and trending down
Root cause: change management. Rapid onboarding of new staff or depletion of existing staff is strongly correlated with performance metrics
Remediation Plan:
• WPS review of first 3 assessments for all new staff
• Mandatory FSA/supervisor training on change management. Existing training is on change management theory- possibly develop part 2 operationalized change management training in the context of DDA needs around staffing fluctuations
• Develop a monthly report for the field to show clients with PCSP services that are not authorized; expectation that WPS/supervisors follow up with their staff
• CARE tickler notifying field staff of mismatch in PCSP and ProviderOne
• Develop a policy-if service is not authorized within the previous 89 days , an end date will be added in the PCSP. An amendment can be added later when the service is able to be authorized.
Implementation Plan:

HQ Responsibilities	*Field Implementation Expectations*
Identify Change Management trainings	
• Make change management a mandatory training for field leadership (Supervisors, specialists and FSAs)	*• Prioritize change management training*
• Develop an operationalized change management training specific to implementation, for supervisors	*• Take Change Management training*
	• Provide feedback about change management needs
WPS review of first 3 assessments for all new staff	
• Include review of expectations in a remediation plan MB	*• New staff will submit their first 3 assessments for waiver specialist review*
	• Waiver Specialists will provide feedback to supervisors and/or HQ if staff are needing more support
Develop a monthly report that is sent to field for correction	
• Create monthly report pulling Plan Effective Date for previous 60 days	*• Supervisors to follow up with CRMs and identify barriers to authorizing services*
• Send list of clients with services in the PCSP that are not authorized in P1	*• If a service is not authorized within 89 days, put an end date on the service*
• Provide a timeline to field to correct PCSP services not authorized	*• CRM can do a plan amendment when the client is ready to begin the service*
Develop MB and Policy on Remediation Expectations	
• HQ will outline clear expectations related to 90 implementation of services, effective date of the MB, to implement the remediation strategies and all of the above mentioned strategies.	*• Field staff will begin, at*

QIP for Performance Measure-D.d.3 - The percentage of waiver PCSPs with service authorizations in place for waiver funded services that occurred that should have occurred in the last 3 months.

Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measure D.d.3: The percentage of waiver PCSPs with service authorizations in place for waiver funded services that occurred that should have occurred in the last 3 months. N = All waiver PCSPs reviewed with service authorizations for waiver funded services that occurred that should have occurred in the last 3 months. D = All waiver PCSPs reviewed that should have included a service authorization in the last 3 months.

Current compliance is 85% and trending down
Root cause: change management. Rapid onboarding of new staff or depletion of existing staff is strongly correlated with performance metrics
Remediation Plan:
- *WPS review of first 3 assessments for all new staff*
- *Mandatory FSA/supervisor training on change management. Existing training is on change management theory- possibly develop part 2 operationalized change management training in the context of DDA needs around staffing fluctuations*
- *Develop a monthly report for the field to show clients with PCSP services that are not authorized; expectation that WPS/supervisors follow up with their staff*
- *CARE tickler notifying field staff of mismatch in PCSP and ProviderOne*
- *Develop a policy that by day 89, if service is not authorized, an end date will be added in the PCSP. An amendment can be added later when the service is able to be authorized*

Implementation Plan:

HQ Responsibilities	*Field Implementation Expectations*
Identify Change Management trainings	
• Make change management a mandatory training for field leadership (Supervisors, specialists and FSAs)	*• Prioritize change management training*
• Develop an operationalized change management training specific to implementation, for supervisors	*• Take Change Management training*
	• Provide feedback about change management needs
WPS review of first 3 assessments for all new staff	
• Include review of expectations in a remediation plan MB	*• New staff will submit their first 3 assessments for waiver specialist review*
	• Waiver Specialists will provide feedback to supervisors and/or HQ if staff are needing more support
Develop a monthly report that is sent to field for correction	
• Create monthly report pulling Plan Effective Date for previous 60 days	*• Supervisors to follow up with CRMs and identify barriers to authorizing services*
• Send list of clients with services in the PCSP that are not authorized in P1	*• If a service is not authorized within 89 days, put an end date on the service*
• Provide a timeline to field to correct PCSP services not authorized	*• CRM can do a plan amendment when the client is ready to use the service*
Develop MB and Policy on Remediation Expectations	
• HQ will outline clear expectations related to 90 implementation of services, and all of the above mentioned strategies.	*• Field staff will begin, at effective date of the MB, to implement the remediation strategies*

Update for D.d.2 and D.d.3:
- *"For D.d.2 and D.d.3, state used a representative sample, 95% confidence level with a +/- 5% margin of error for all 3 waiver years. The sample universe increased from WY2 to WY3 as a correction to show the entire sample universe of total waiver participants. Sample size instead of sample universe was used in WY1 and WY2 in error. State is compliant for D.d.2 and D.d.3 in WY4. For D.d.2., 273 files were compliant out of a sample size of 311 for 88% compliance. For D.d.3. 281 files were compliant out of a sample size of 311 for 90% compliance. It was found that non-waiver services had been factored into previous WY1-3 data. WY4 accurately represents the State's compliance with these 2 performance measures.*
- *The increase in compliance from WY2 to WY3 can be attributed to training of new case management staff to authorize services which are in the PCSP accurately and timely. "*

QIP for Performance Measure D.e.1 - The percentage of waiver participant records that contain the annual

assessment meeting wrap-up, which includes verification that the waiver participant had a choice between/among waiver services and providers.

Sub-Assurance-client has a choice of providers and services

Performance Measure D.e.1: The percentage of waiver participant records that contain the annual assessment meeting wrap-up, which includes verification that the waiver participant had a choice between/among waiver services and providers. N = Number of waiver participant records containing the annual assessment meeting wrap-up. D = All waiver participant records reviewed.

Current compliance is 92% and trending up
Root cause: Field Staff compliance, hard file
Remediation Plan:
• CARE change request plan review screen to include verbiage "client had a choice of providers" and "client had a choice of services". This would then populate onto the PCSP summary and the client signature would indicate client satisfaction with planned providers and services.
• Reminder of Waiver wrap up forms and the opportunity to have a conversation with clients about their services
Remediation Goal: CRMs understand the value of the form and there is a support system in place for filing
Implementation Plan:
HQ Responsibilities *Field Implementation Expectations*

CARE Change Request

• Add verbiage to the CARE plan review screen to allow client opportunity to discuss choice of providers and services and make any changes
• At 6 month plan review, CRMs document on plan review screen that the client was satisfied OR made changes to services or service providers.

Develop MB and Policy on Remediation Expectations

• HQ will outline clear expectations related to waiver wrap up forms and plan review, and all of the above mentioned strategies
• Field staff will begin, at effective date of the MB, to implement the remediation strategies

Update for D.e.1:
• For D.e.1, State used a representative sample, 95% confidence level with a +/- 5% margin of error for all 3 waiver years. The sample universe increased from WY2 to WY3 as a correction to show the entire sample universe of total waiver participants. Sample size instead of sample universe was used in WY1 and WY2 in error. 2 new mandatory questions added to CARE System on 12/30/22, (Checkbox) "Provider options were discussed and client had a choice of qualified providers." And (Checkbox) "Services were discussed and client had a choice of services." Will adjust data source to CARE system, 100% data in next waiver renewal.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

a) Providers are not required to have an independent financial audit of their financial statements. Agency providers are required to submit a cost report. If the department has reason to be concerned, the department will request an audit by Operations Review and Consultation or the State Auditors Office. Operations Review and Consultation is within DSHS. The State Auditors Office is a state agency outside the Department of Social and Health Services.

b) The Office of Rates Management annually conducts desk audits on all annual cost reports submitted by providers. The revenues reported by providers are reconciled to the payments made through ProviderOne and Individual ProviderOne for services and the provider's contract(s) in place during the period. The Office of Rates Management may require additional information from the provider (payroll records, other financial records, etc.) if there are concerns about the integrity of the cost report information. The Office of Rates Management may also conduct on-site reviews of provider financial records to ensure that the cost report is accurate and completed in accordance with contract requirements. First, only claims that have an approved authorization can be paid. If a claim is determined to be inappropriate, the authorization will be amended and an adjustment will be made to the claim that will cause it to reprocess, deny, and the resulting debt that is created will be sent to the Office of Financial Recovery for collection. FFP is revised to match the corrected authorization.

The CDE is required to have an annual independent financial audit and provide the results to the state.

The Office of Rates Management audits cost reports submitted by residential providers in accordance with the processes and procedures outlined in DDA Policy 6.04 Cost Reports for Supported Living, Group Training Homes, and Group Homes and DDA Policy 6.02 Rates, Billing, and Payment for Supported Living, Group Training Homes and Group Homes to ensure provider costs do not include unallowable expenses, such as the cost for room and board. State utilizes a tiered rate methodology where the rate varies by identified characteristics of the individual client, county of residence and composition of the household. Nine tiers are formed by matching individuals, stratified by the DDA assessment, with associated payment brackets, which are based on average cost of service. Cost reports are submitted by residential providers to the State on a State-designed form and include the following rate components: instruction and support services (ISS), administrative, transportation, residential professional services and other non-ISS supports. Additional allowable costs may include cost of care adjustments, staff add-on for client-specific need, client transition and summer program for supported living clients. Detail in the cost reports and supporting documents provided by residential providers help rates management auditors ensure accurate cost reports by verifying: all sections of the cost report are complete; all information matches the ProviderOne payment report; the report conforms with generally accepted accounting principles; and the reports meet the requirements of the providers contract.

On-site reviews conducted by the Office of Rates Management are at their sole discretion and may occur if the Office of Rates Management deems it necessary to validate the information contained in the cost report by reviewing provider financial records.

The Office of Rates Management sends a letter to the provider describing the results for both the desk and on-site audits. If the state requires correction action plans from providers, the Office of Rates Management will follow-up with the providers to verify that the corrective action plans have been completed evidenced by corrected cost reports and audited financial records.

c) The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.d)Federal rules are followed for agencies that have non-profit status per the Single Audit Act and OMB Circular A-133. A single or program specific audit is required for the AAA and other subcontractors who expend more than $750,000 in federal assistance in a year.

The State implemented EVV for Personal Care, Skills Acquisition, Respite and Relief Care provided by individual providers and home care agencies effective January 1, 2021. EVV utilizes a 21st Century Cures Act compliant mobile application, Time4Care, to capture and report the six required data elements: 1) type of service performed including service delivery detail, activities and visit notes; 2) who received the service; 3) real time capture of date of the service; 4) who provided the service; 5) real time capture of location of service delivery via GPS; and 6) when the service begins and ends using real time clock in/clock out functionality.

• EVV is used to monitor the State's financial integrity and accountability and reduce fraud, waste and abuse. The EVV application, Time4Care, has the following features:

- *is 21st Century Cures Act compliant;*
- *allows for the control and flexibility of service delivery;*
- *the application is simple to use and records time offline without an internet connection;*
- *Time4Care is integrated with the WA IPOne web portal;*
- *Error trapping – Time4Care lets providers know in real time if there are problems with their data entries;*

- *Time4Care is designed to mitigate fraud, waste and abuse.*

This waiver provides Skilled Nursing, the only Home Health Care Service which is subject to the State's fully implemented EVV system.

The State's EVV system allows the location data, time-in and time-out data provided by the EVV system to be seen as a component of the State's MMIS, ProviderOne, which permits detailed monitoring of Skilled Nursing service delivery to waiver participants in their homes.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
I.a.1. # & % of claims coded & paid in accordance with reimbursement methodology in approved waiver for waiver services rendered per waiver participant's PCSP with documented service delivery. N = # of claims coded & paid in accordance with reimbursement methodology in approved wvr for wvr services rendered per wvr part's PCSP with documented service delivery. D = # of wvr claims reviewed.

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***

☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with a +/- 5% margin of error*
☒ ***Other*** *Specify:* *Quality Compliance Coordinator (QCC) Team within DDA.*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
I.b.1. # & % of waiver provider rate methodologies utilized by contract specialists that are consistent with rate methodology in approved waiver application. N = # of wvr provider rate methodologies utilized by contract specialists that are consistent with rate methodology in approved wvr application. D = # of wvr provider rate methodologies utilized by contract specialists that were reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Agency Contracts Database (ACD)

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with a +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

I.a.1:
The Waiver Team completes a review of all paid claims files across all waivers annually using the ProviderOne MMIS. Findings that require corrections are referred to Payment Specialists who will work with case resource managers to make necessary corrections within 90 days.

I.b.1: Waiver Team annually audits a stratified random sample of provider contracts across all waiver services to verify that provider rate methodologies utilized by contract specialists are consistent with the rate methodologies in the approved waiver. When unapproved rate methodologies are found, contract specialists are notified and contracts are modified or terminated. Waiver Team follows up with contract specialists to verify that contracts are modified or terminated.

b. Methods for Remediation/Fixing Individual Problems

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

I.a.1. Annual waiver file review:
Findings from Waiver Team and Supervisor file reviews are analyzed by DDA staff and reviewed by DDA management. Based on the analysis necessary steps are taken to increase compliance. For example:
- *Annual Waiver Training curriculum is developed in part to address review findings.*
- *Personnel issues are identified.*
- *Form format and instructions are modified.*
- *Waiver WAC is revised to clarify waiver rules.*
- *Regional processes are revised.*

Providers whose service authorization included a rate higher than the contracted rate are reviewed to determine the appropriate course of action. Overpayments are processed as necessary.

I.b.1.: Waiver Team annually audits a stratified random sample of provider contracts across all waiver services to verify that provider rate methodologies utilized by contract specialists are consistent with the rate methodologies in the approved waiver. When unapproved rate methodologies are found, contract specialists are notified and contracts are modified or terminated. Waiver Team follows up with contract specialists to verify that contracts are modified or terminated.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*

c. Timelines

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

- ◉ ***No***
- ○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

All negotiated rates comply with Federal and Washington State minimum wage requirements.
The DDA and the Health Care Authority follow the federal guidelines found in 42 U.S.C. § 1396a(a)(30)(A) when establishing rates so that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist providers for services to ensure adequate access to care for Medicaid recipients. Steps taken to ensure rates comply with federal requirements include: workgroups, stakeholder meetings, consultation with program managers, consultation with professional organizations, analysis of market rates, rates paid by other states for comparable services, and the budget impacts of rates. For example, for nursing services, comparable services in the private sector and in other states include private duty nursing/in-home nursing as provided by LPNs or RNs.
Payment cannot exceed 1) the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged for comparable services funded by other sources. Methods for determining reasonable rates include periodic market surveys, cost analysis and price comparison. HCA conducts these activities every two to four years, per requests by the Legislature and/or indications that access to services is being impacted by current rates. For DDA rates, this information has been added below under each set of services.
Waiver service definitions and provider qualifications are standardized. This helps ensure that rates are comparable (not necessarily identical) across the state for those services that are negotiated on a regional basis by DDA staff, as rates are for identical services with providers meeting the same qualifications.
HCA rates are updated every January with any possible new codes, and rates are changed every July to align with the new relative value units (RVUs), State geographic price cost index (GPCI), and State specific conversion factor. For codes that do not have RVUs, rates are usually set at a flat rate. If analysis shows they need to be updated, that happens every July with the other codes. The most recent update was in July 2024, and are reviewed every July.
With respect to rates established by DDA, the most recent rate comparison was conducted in the January of 2019. If a rate change is not budget neutral, it would be made only if funding was provided by the Legislature or the Legislature required service coverage changes to save the funding needed for the rate change.
For HCA-based rates, an amendment to the rates is triggered by directive and/or funding by the Legislature, and/or a change to RVUs, and the Legislature is responsible for funding rate changes. The HCA identifies the need for a rate change using indicators listed below. Without additional funding, rate changes must be budget neutral. If a rate change is not budget neutral, it would be made only if funding was provided by the Legislature or the Legislature required service coverage changes to save the funding needed for the rate change.
For DDA, specifics regarding when rates are adjusted & the criteria used to evaluate the need for rate adjustments are at the end of the discussion of each set of services. When funding is available, the Legislature mandates rate increases for specific types of vendors (e.g., individual providers, residential providers, adult family homes) and/or services.
Regarding criteria for HCA to adjust rates, RVU driven rates are updated yearly per new RVUs. For flat rates, a significant (e.g., 25%) drop in the use of services by Medicaid participants, a significant (e.g., 25%) drop in the number of enrolled providers, an indication that payment rates are substantially (e.g., 40%) below third-party insurer rates, and/or a request by the Legislature for an analysis of rate adequacy are indicators of the need for rate adjustments. Rates are adjusted with approval from the Legislature.
Rates negotiated with employee unions are static during the life of the contract & are the rates identified within the contract. These rates are only adjusted as written within the contract.
Regarding the cost allocation plan, DSHS does not establish indirect rates for Title XIX administration. A Public Assistance Cost allocation plan allocates administrative costs through various allocation methodologies (see attachment for the most current submission). The Public Assistance Cost Allocation plans for DDA & ALSTA describe the cost allocation methodologies to the CFDA (Medicaid) grant level & does not list specific waivers.
While the Public Assistance Cost Allocation plan for the DDA (submitted as a PDF attachment) does not list specific waivers, the cost accounting system allocates the Medicaid portion to the specific funding of the clients served. A portion of the cost of all DDA staff (e.g., regional staff associated with community-based services, Central Office staff including the waiver unit staff & administrative & management staff) who provide administrative and/or technical support to the waiver program is charged as Title XIX administration & allocated by the funding source of the clients served (both state plan & waiver).
There will be no administrative charges for the IFS waiver until client services under the approved waiver are provided & paid, since the portion of staff costs charged to Title XIX administration is based on either caseload or expenditures for Title XIX services.

The State engages in significant public input processes outlined in Main Section 6-I.

Rates do not vary by geographical location.
Community Engagement: Flat Fee
Peer Mentoring: Flat Fee

Person-Centered Plan Facilitation: Flat Fee
Nurse Delegation: Flat Fee set by legislature
Skilled Nursing: Flat Fee set by legislature
Supported Parenting: Flat Fee aligned with staff/family consultation

Assistive Technology, Specialized Clothing, Specialized Equipment & Supplies, and community-based settings for respite services: Rates are based on usual & customary charges for the products/services as paid by the general public. Charges are adjusted by the supplier based on overhead, staff wages & the local demand for the products/services. To maintain availability of these products/services for waiver participants, DDA adjusts rates annually if rate comparisons indicate prevailing market rates have increased significantly (e.g., 20%+).

Community Engagement, Peer Mentoring, Person Centered Plan Facilitation: Rates are standardized & state-wide based on the skills required. Rates will be adjusted as necessary based on the demand for the services, availability of providers, & adjustments in rates made to providers of services that require similar skill levels. Rate changes may be initiated by providers or by DDA. DDA will review the adequacy of the rates annually using rate comparisons. Rates will be changed if current rates will result in providers terminating their contracts & rate comparisons indicate IFs Waiver payment rates are at least 20% less than those for individuals with comparable skills.

Extended State Plan Services (Occupational Therapy, Physical Therapy and Speech, Hearing & Language Services): These services are paid via ProviderOne, Washington State's approved MMIS. These rates are established by the HCA & are updated every January with any possible new codes, & rates are changed every July to align with new RVUs, State GPCI, and State specific conversion factor. The most recent update was in July 2024, and are reviewed every July.

Respite: The Washington State Legislature determines the rates for the following providers:
• CDE who employs Individual Providers of respite
• Transportation provided by Individual Providers of respite
• Home Care Agencies
Respite rate methodology: Individual and Home Care Agency respite providers:
Respite rates are based on a per hour unit and is determined by a rate setting board and approved by the State legislature. The rate includes wages, L & I, vacation pay, mileage reimbursement, comprehensive medical, training, and seniority pay. For individual providers who have completed the home care aide certification, the hourly rate also includes a certification differential payment. Due to the agency parity law [RCW 74.39A.310(1)(a)(v)] the home care agency vendor rates are equivalent to that of the individual provider rate. Rates for Individual Providers of respite, transportation provided by Individual Providers of respite and Home Care Agencies will be reflected in the published fee schedule based upon the state fiscal year July 1 through June 30. The fee schedule is updated at least annually to reflect any rate changes resulting from legislative action or collective bargaining. Rate changes are determined through legislative action and appropriation. Rates may be reviewed annually during the 5-year period or sooner if rates are not sufficient to meet economy, efficiency, or quality of care to enlist enough providers.
Changes to rates for Individual Providers: The rate setting board reviews the rates every two years for Individual providers. Changes to rates for Agency Providers: Due to the agency parity law [RCW 74.39A.310(1)(a)(v)] the home care agency vendor rates are equivalent to that of the individual provider rate. • Enabling legislation set the starting rates in 2019 and due to the delayed implementation to 2021, the rates have been updated to July 2023.
Waiver services rates have been reviewed in the last five years on varying schedules. Residential habilitation provider rates were last reviewed and many rebased in 2019, assistive technology, specialized equipment and supplies, environmental adaptations, nursing, person centered plan facilitation, staff/family consultation, supported parenting, respite, and community engagement rates were reviewed and rebased when appropriate, in 2021/2022, and peer mentoring, specialized habilitation, music and equine therapy, and risk assessment were reviewed in 2022 for potential rebasing, and determined not necessary in 2023; the State will review rates again in 2024/2025 for possible rebasing.
Service rates are not determined geographically.
Continued at Main. B-Optional

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The Department of Social and Health Services (DSHS), the State Operating Agency, receives funding appropriated by the Legislature in the biennial budget. Funding (both state dollars and federal dollars) is provided to DSHS and allotted to the Developmental Disabilities Administration (DDA). DDA receives the appropriation and allots funds to its operating regions via Regional Budgets for most service (e.g., residential, personal care, professional) categories.
Direct Service Payments
Washington State's Health Care Authority (the single state Medicaid Agency) has a MMIS titled "ProviderOne". The State makes most payments for client services through ProviderOne. Once a provider is authorized for a service that the provider must claim, the provider provides the service and submits the claim directly into the MMIS ProviderOne system. Payments are issued by EFT or Warrant.
Case managers pre-authorize services based on the assessed need for the services. After the goods or service are provided the provider then reports the amount of service provided by date of service and are paid based on their claim. ProviderOne is an integrated MMIS system that manages medical and social service claims. Independent contractors who receive a 1099 tax form are paid directly through ProviderOne. Individual providers who receive a W2 for reportable wages are paid through a payroll system operated by the CDE. All authorization and claim data regardless of provider type is integrated and reportable in ProviderOne and the ProviderOne data warehouse.
Payments to State Employees
The State-Operated Living Alternatives (SOLA) programs are supported living program staffed with state employees. Employee salaries are included in the appropriation provided to the Administration by the Legislature. Salaries for State-staffed stabilization services - crisis diversion bed as components of stabilization services are also included in the appropriation provided to the Administration by the Legislature. State employees that provide these services are paid twice a month like other state employees, with the payment amount determined by their job classification and experience.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

***c. Certifying Public Expenditures** (select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

a.) Individual was eligible for Medicaid waiver payment on the date of service.

1) ProviderOne has a waiver identifier based on waiver status that indicates an individual is on a home and community-based services waiver.

2) Waiver Status in CARE Waiver Screen The Developmental Disabilities Administration's CARE includes a Waiver Screen that contains the type of waiver an individual is on, the waiver begin date, and waiver end date (if any). A waiver effective date for the individual is entered into the Waiver Screen by CARE once the necessary waiver eligibility confirmation steps have been completed. These include verification of the need for ICF/IID Level of Care (LOC) and financial eligibility (as established by financial workers in the Long Term Care & Specialty Programs Unit within DDA), documentation of Voluntary Participation statement (Form #10-424), verification of disability per criteria established in the SSA, and completion of an Person-Centered Service Plan (PCSP). CARE enters a waiver effective date based on the effective date of the person-centered service plan (PCSP), which is the last step in the waiver eligibility verification process. The waiver effective date serves as the beginning date for claiming of federal financial participation for waiver services. Case Resource Managers may only assign a waiver Recipient Aid Category (RAC) once the steps outlined above are complete. Should a waiver RAC be assigned but a participant has a lost of financial eligibility during the coverage period, ProviderOne will post edits.

The usual MMIS edits will be applied to billings under the IFS Waiver. I.e., the following will be verified: the individual is on the IFS Waiver, the service is covered under the IFS Waiver, the provider is a valid provider of the service, the provider is a qualified provider with a current contract, and the specifics of the claim are consistent with the service authorization completed by the DDA case resource manager.

b.) Service was included in the participant's approved person-centered service plan to assure the pre-payment process for validating provider billings. PCSPs are updated as needed and at least annually (please see Appendix H-1.b.3 for a description of the steps taken to ensure PCSPs are updated).

DDA Quality Compliance Coordinators (QCCs) annually review a statewide sample of clients. Their review includes a comparison of service payments with the services contained in approved PCSPs to ensure that services claimed against the IFS Waiver are contained in the approved PCSP.

c.) The services were provided.

Monitoring of the provision of services is outlined in Appendix H-1-b-4. Steps taken include:

• QCC file reviews verify the authorization matches the PCSP including the type, scope, amount, duration and frequency of the service. When findings occur, regions have 30 days to correct problems. QCCs monitor the corrective action plans.

• CRMs or Social Service Specialists complete a review of last year's plan with the waiver recipient prior to beginning the planning process for the upcoming year. A portion of the review is to confirm that services were received in accordance with the PCSP.

• The State participates in the National Core Indicators Survey, which includes waiver related questions. This annual face-to-face sampling of waiver participants enables DDA management to evaluate PCSP outcomes from the recipient's perspective.

Services provided in state operated settings are not billed through the MMIS. These State-operated services have the same assurances of validation as
State-contracted services paid through the MMIS:

- *The person is enrolled and meets eligibility requirements for the waiver program on the date of service.*
- *The service type, scope, amount, duration and frequency are identified in the approved service plan.*
- *There is documentation of the service and the state operated setting meets certification, licensing, training and other requirements.*
- *Individuals receiving waiver services in state operated settings receive case management visits at least annually or when there is a significant change.*

The state's CARE system compiles the information for the essential tests along with residence leave to settings such as hospitals or nursing facilities to identify dates of service that are eligible to claim match and are reconciled monthly prior to claim of match.

The state adjusts FFP whenever an incorrect billing is identified. This is done by adjusting the claim in MMIS. The state adjusts billings when reconciliations reveal a change in status or eligibility of a client. The state also adjusts billings when reconciliations reveal inappropriate billings (duplicate billings, billings for non-waiver services, etc.) and removes them from claims for FFP.

Revised PMs D.a.1, D.a.2, D.d.1, D.d.2, D.d.3, D.d.4 & D.d.5 all measure various means of verification that planned services were provided.

Continued at Main.A.Attachment #2

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

The State makes most payments for client services through ProviderOne. ProviderOne is an unified Medicaid payments system that provides enforcement and assurance that case resource managers and providers are compliant with rules and policy. Once a provider is authorized for a service that the provider must claim, the provider provides the service and submits the claim directly into the MMIS ProviderOne system. Payments are issued by EFT or Warrant. In ProviderOne payments are based on an authorization by the case resource manager however there is not an invoice processed. Both providers and clients are notified of creation or changes to authorization. The provider then submits an online claim for payment based on the units provided. Claims are specific to the date of service. Providers can claim as often as daily if they choose. Payment can be made as frequently as weekly. A report of time worked by date will be required before payment will be made.
ProviderOne is an unified Medicaid payments system that provides enforcement and assurance that case resource managers and providers are compliant with rules and policy.
Example of benefits of ProviderOne:
• Client and provider eligibility is checked at the authorization and at the claim. If a client does not have the correct financial eligibility or does not meet waiver criteria such as having an individualized assessment or is not ICF/IID eligible an authorization error will populate preventing payment prompting the case resource manager to either resolve the error or work with the client to help them meet eligibility criteria. If providers do not have the correct contract or correct credential, if required, for the authorized service an authorization error will populate and payment will not be made. Washington utilizes one system to process claims pertaining to the services provided to waiver participants. For Individual Providers of respite, payments are processed through their employer, the CDE. The CDE uses the State's MMIS system for all claims. CDE's phase-in was completed May 31, 2022. No new services will be claimed by Individual providers through the ProviderOne billing system. Poaitive Behavior Support and Consultation was removed from this waiver effective September 1, 2022.

Services provided in state operated settings are not billed through the MMIS. These State-operated services have the same assurances of validation as State-contracted services paid through the MMIS:
• The person is enrolled and meets eligibility requirements for the waiver program on the date of service.
• The service type, scope, amount, duration, and frequency are identified in the approved service plan.
• There is documentation of the service, and the state operated setting meets certification, licensing, training, and other requirements.
• Individuals receiving waiver services in state operated settings receive case management visits at least annually or when there is a significant change.

The State is a limited fiscal agent for waiver services performed by state employees. The State-Operated Living Alternatives (SOLA) programs are supported living program staffed with state employees. Employee salaries are included in the appropriation provided to the Administration by the Legislature. Salaries for State-staffed stabilization services - crisis diversion bed as components of stabilization services are also included in the appropriation provided to the Administration by the Legislature. State employees that provide these services are paid twice a month like other state employees, with the payment amount determined by their job classification and experience. Service authorizations for waiver services performed by state employees are processed and documented through the CARE system's person-centered service plan in the same manner as all other waiver services.

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The Department of Social and Health Services (DSHS), the State Operating Agency, receives funding appropriated by the Legislature in the biennial budget. Funding (both state dollars and federal dollars) is provided to DSHS and allotted to the Developmental Disabilities Administration (DDA). DDA receives the appropriation and allots funds to its operating regions via Regional Budgets for most service (e.g., residential, personal care, professional) categories.
Direct Service Payments
Washington State's Health Care Authority (the single state Medicaid Agency) has a MMIS titled "ProviderOne". The State makes most payments for client services through ProviderOne. Once a provider is authorized for a service that the provider must claim, the provider provides the service and submits the claim directly into the MMIS ProviderOne system. Payments are issued by EFT or Warrant.
Case managers pre-authorize services based on the assessed need for the services. After the goods or service are provided the provider then reports the amount of service provided by date of service and are paid based on their claim. ProviderOne is an integrated MMIS system that manages medical and social service claims. Independent contractors who receive a 1099 tax form are paid directly through ProviderOne. Individual providers who receive a W2 for reportable wages are paid through a payroll system operated by the CDE. All authorization and claim data regardless of provider type is integrated and reportable in ProviderOne and the ProviderOne data warehouse.
Payments to State Employees
The State-Operated Living Alternatives (SOLA) programs are supported living program staffed with state employees. Employee salaries are included in the appropriation provided to the Administration by the Legislature. Salaries for State-staffed stabilization services - crisis diversion bed as components of stabilization services are also included in the appropriation provided to the Administration by the Legislature. State employees that provide these services are paid twice a month like other state employees, with the payment amount determined by their job classification and experience.

The State is a limited fiscal agent for waiver services performed by state employees. The State-Operated Living Alternatives (SOLA) programs are supported living program staffed with state employees. Employee salaries are included in the appropriation provided to the Administration by the Legislature. Salaries for State-staffed stabilization services - crisis diversion bed as components of stabilization services are also included in the appropriation provided to the Administration by the Legislature. State employees that provide these services are paid twice a month like other state employees, with the payment amount determined by their job classification and experience. Service authorizations for waiver services performed by state employees are processed and documented through the CARE system's person-centered service plan in the same manner as all other waiver services.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care

entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

DSHS/DDA is the authorizing agency for all services payments. All payments and appropriations are managed through the State's MMIS in accordance with an MOU between DSHS and the Health Care Authority (Single State Medicaid Agency). The legislature make appropriations directly to DDA and HCA manages payments to vendors per the MOU between HCA and DSHS via the MMIS.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Group Care Home/Group Training Home
The claim for Federal Financial Participation (FFP) for respite care in group homes and group training homes is based on the cost of respite services only. The rate for respite does not include the cost of room and board.

Child Foster Care
Payment for respite care in a foster home is only made for the cost of respite services. The rate for respite does not include the cost of room and board.

Staffed Residential Home
Payment for respite care in a staffed residential home resident is made only for the cost of respite services. The rate for respite does not include the cost of room and board.

Child Foster Group Care
Payment for respite care in a foster group care facility is made only for the cost of respite services. The rate for respite does not include the cost of room and board.

Adult Family Home
The basic rate for an adult family home covers the cost of room and board and is made under a separate payment code. That payment is off-set by client income/SSI payments. State payments for room and board are account-coded to all state dollars (i.e., are not account-coded against DDA's home and community-based services IFS Waiver).

Adult Residential Care Facility
The basic rate for adult residential care covers the cost of room and board and is made under a separate payment code. That payment is off-set by client income/SSI payments. State payments for room and board are account-coded to all state dollars (i.e., are not account-coded against DDA's home and community-based services IFS Waiver).

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	775.48	17535.00	18310.48	356491.00	2900.00	359391.00	341080.52
2	931.46	18590.00	19521.46	413807.00	2819.00	416626.00	397104.54
3	1085.09	19645.00	20730.09	471124.00	2737.00	473861.00	453130.91
4	1241.79	20700.00	21941.79	528441.00	2655.00	531096.00	509154.21
5	1397.44	21755.00	23152.44	585758.00	2574.00	588332.00	565179.56

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(1 of 9)*

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	9000	9000
Year 2	9000	9000
Year 3	9000	9000
Year 4	9000	9000
Year 5	9000	9000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

State derived regression formula Y = 33.29X + 150.59 from ALOSs of accepted CMS 372 reports for 2016-2017 through 2020-2021(154.7, 241.1, 271.4, 286.8, and 298.3) to project ALOS for WY1 of 284, WY2 of 317 and WY3-WY5 of 350.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Regression formulas based on IFS participant counts and service expenditures in accepted IFS CMS 372 reports from waiver years 2015-2016 through 2020-2021 were used to project base participant counts and base expenditures for WY1-5 in the renewal for the following services:

- *Respite –*
  - *Count Regression: Y = 454.48571X + 999.46667*
  - *Expenditures Regression: Y = 1125422.11429X + 612900.93333*
- *Community Engagement –*
  - *Count Regression: Y = 14.82857X + 9.26667*
  - *Expenditures Regression: Y = 15881.85714 + 2736.33333*
- *Environmental Adaptations –*
  - *Count Regression: Y = 6.2X + 0.8*
  - *Expenditures Regression: Y = 37906.54286X + 44250.4*
- *Specialized Equipment & Supplies –*
  - *Count Regression: Y = 222.42857X – 342*
  - *Expenditures Regression: Y = 135233X – 217793*
- *Transportation –*
  - *Count Regression: Y = 8.62857X + 14.46667*
  - *Expenditures Regression: Y = 1774.91429X + 1395.8*
- *Wellness Education –*
  - *Count Regression: Y = 945.74286X + 29.73333*
  - *Expenditures Regression: Y = 25155.17143X – 21709.6*
- *Assistive Technology –*
  - *Count Regression: Y = 32.85714X – 2.33333*
  - *Expenditures Regression: Y = 18790.17143X + 5163.4*

Unit costs for services estimated using regression formulas are based on WY5 values from the previous waiver cycle and are not inflated due to the latest CPI-M index trends (downward - reference at the end of this section). Units of service are calculated as a "plug" value with unit costs from WY5 values, and participant counts and total expenditures being givens from the regression formulas.

Additional DCYF participant counts and expenditures are added to the services base counts and base expenditures for the projected 595 additional DCYF participants (distribution of projected DCYF enrollees by waiver was derived by calculating the distribution of all current waiver clients age 20 and younger by waiver as a percentage of all waiver enrollees age 20 and younger across all waivers (data from WY2)) added in WY1 for services projected using the regression methodology above and for services using the annual percentage increase below. Additional participant counts and expenditures are derived from the percentage distribution of waiver services in WY5 of the previous waiver cycle (for example, 58.2% of waiver participants utilized respite; therefore 58.2% X 595 additional DCYF participants = 346 participants who will likely utilize respite in WY1). The following services added the following projected DCYF participant counts in WY1:

- *Respite 346*
- *Community Engagement 12*
- *Environmental Adaptations 3*
- *Specialized Equipment & Supplies 21*
- *Staff/Family Consultation 2*
- *Transportation 6*
- *Wellness Education 414*
- *Assistive Technology 14*
- *Specialized Habilitation 3*
- *Specialized Clothing 2*
- *Person-Centered Plan Facilitation 1*
- *Stabilization Services – Specialized Habilitation 1*
- *Stabilization Services – Staff/Family Consultation 1*

The services not using the regression methodology are projected to experience 3% annual count increases from the base counts in WY5 of the previous waiver cycle based on the professional judgement of State staff. The State relies on the professional judgement of staff with over ten years of experience writing over 102 approved waiver amendment and renewal applications for Washington State's five developmental disability 1915(c) waivers. Professional judgement is seasoned by preparing ten years of CMS 372 reports with data from Washington State's MMIS. Because CPI-M data for the most recent year (June 2022 – May 2023) shows a 4.3% decrease in this index, service unit costs are projected with no increases for WY1-5. Units of service will be based on units of

service in WY5 of the previous waiver cycle. Modifying the transportation service definition will likely increase users and units of service to meet the level of currently projected users and units of service as current actual number of users and units of service are below projected numbers.
The State notes that the increases in utilization for Staff/Family Consultation Services are based on two components as explained in J-2-c-I; the first component is the base count from WY5 of the previous waiver cycle that increases at a 3% rate each waiver year; and the second component is the projected increase based on DCYF children and youth which for this service is 2 participants added in WY1.
U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care Services in U.S. City Average [CUSR0000SAM2], retrieved from FRED, Federal Reserve Bank of St. Louis, June 27, 2023.

For the waiver amendment effective 1/01/2025, Life Skills and Stabilization Services - Life Skills split user counts for WY 1 with Specialized Habilitation and Stabilization Services - Specialized Habilitation, respectively. In WYs 2-5, Specialized Habilitation and Stabilization Services - Specialized Habilitation are zeroed out. Estimates for number of users, average units per user, and average cost per unit for Life Skills and Stabilization Services - Life Skills have been added for WYs 1-5.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

State derived regression formula Y = 1055X + 13315.2 from actual Factor D' of waiver years 2016-2017 through 2020-2021 from accepted CMS 372 reports ($14,861, $17,066, $17,727, $8,156, and $24,591) to project Factor D' for WY1 of $17,535, WY2 of $18,590, WY3 of $19,645, WY4 of $20,700, and WY5 of $21,755. Projected Factor D' includes managed care premiums, fee for services expenditures and Community First Choice expenditures.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

State derived regression formula Y = 57316.81X + 127223.324 from actual Factor G of waiver years 2016-2017 through 2020-2021 from the State's MMIS ($213,746.61, $231,327.94, $271,684.78, $326,229.62, and $452,879.82) to project Factor G for WY1 of $356,491, WY2 of $413,807, WY3 of $471,124, WY4 of $528,441 and WY5 of $585,758.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

State derived regression formula Y = -81.56X + 3226.298 from actual Factor G' of waiver years 2016-2017 through 2020-2021 from the State's MMIS ($2,876.72, $3,213.85, $3,489.89, $2,503.57, and $2,824.06) to project Factor G' for WY1 of $2,900, WY2 of $2,819, WY3 of $2,737, WY4 of $2,655, and WY5 of $2,574.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Respite	
Occupational Therapy	
Physical Therapy	
Speech, Hearing and Language Services	
Assistive Technology	
Community Engagement	
Environmental Adaptations	

Waiver Services	
Life Skills	
Nurse Delegation	
Peer Mentoring	
Person-Centered Plan Facilitation	
Remote Supports	
Risk Assessment	
Skilled Nursing	
Specialized Clothing	
Specialized Equipment and Supplies	
Specialized Habilitation	
Stabilization Services - Crisis Diversion Bed	
Stabilization Services - Life Skills	
Stabilization Services - Specialized Habilitation	
Stabilization Services - Staff/Family Consultation	
Staff/Family Consultation	
Supported Parenting	
Therapeutic Adaptations	
Transportation	
Vehicle Modifications	
Wellness Education	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**5701436.16**
Respite	☐	Hour	3140	57.90	31.36	**5701436.16**	
Occupational Therapy Total:							**149.01**
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
					GRAND TOTAL:		**6979333.73**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		6979333.73
					Total Estimated Unduplicated Participants:		**9000**
					Factor D (Divide total by number of participants):		**775.48**
					Services included in capitation:		
					Services not included in capitation:		775.48
					Average Length of Stay on the Waiver:		284

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and Language Services	☐	Hour	1	1.30	114.62	**149.01**	
Assistive Technology Total:							**93587.09**
Assistive Technology	☐	Each	142	0.80	823.83	**93587.09**	
Community Engagement Total:							**76782.00**
Community Engagement	☐	Hour	80	33.50	28.65	**76782.00**	
Environmental Adaptations Total:							**214728.01**
Environmental Adaptations	☐	Each	29	1.90	3897.06	**214728.01**	
Life Skills Total:							**63806.40**
Life Skills	☐	Hour	35	25.32	72.00	**63806.40**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**476.74**
Peer Mentoring	☐	Hour	8	2.60	22.92	**476.74**	
Person-Centered Plan Facilitation Total:							**17326.06**
Person-Centered Plan Facilitation	☐	Hour	19	11.70	77.94	**17326.06**	
Remote Supports Total:							**34962.24**
Remote Supports	☐	Hour	4	922.00	9.48	**34962.24**	
Risk Assessment Total:							**2304.13**

GRAND TOTAL:	**6979333.73**
Total: Services included in capitation:	
Total: Services not included in capitation:	*6979333.73*
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**775.48**
Services included in capitation:	
Services not included in capitation:	*775.48*
Average Length of Stay on the Waiver:	284

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Risk Assessment	☐	Each	1	1.30	1772.41	2304.13	
Skilled Nursing Total:							4229.94
Skilled Nursing	☐	Hour	2	55.25	38.28	4229.94	
Specialized Clothing Total:							8591.56
Specialized Clothing	☐	Each	31	1.30	213.19	8591.56	
Specialized Equipment and Supplies Total:							337956.38
Specialized Equipment and Supplies	☐	Each	567	0.90	662.27	337956.38	
Specialized Habilitation Total:							32814.72
Specialized Habilitation	☐	Hour	18	25.32	72.00	32814.72	
Stabilization Services - Crisis Diversion Bed Total:							113535.63
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	113535.63	
Stabilization Services - Life Skills Total:							12785.76
Stabilization Services - Life Skills	☐	Hour	13	13.66	72.00	12785.76	
Stabilization Services - Specialized Habilitation Total:							5901.12
Stabilization Services - Specialized Habilitation	☐	Hour	6	13.66	72.00	5901.12	
Stabilization Services - Staff/Family Consultation Total:							30602.16
Stabilization Services - Staff/Family Consultation	☐	Hour	19	22.37	72.00	30602.16	

GRAND TOTAL:	6979333.73
Total: Services included in capitation:	
Total: Services not included in capitation:	6979333.73
Total Estimated Unduplicated Participants:	9000
Factor D (Divide total by number of participants):	775.48
Services included in capitation:	
Services not included in capitation:	775.48
Average Length of Stay on the Waiver:	284

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Staff/Family Consultation Total:							**56419.20**
Staff/Family Consultation	☐	Hour	30	26.12	72.00	**56419.20**	
Supported Parenting Total:							**1668.94**
Supported Parenting	☐	Hour	2	9.10	91.70	**1668.94**	
Therapeutic Adaptations Total:							**14400.80**
Therapeutic Adaptations	☐	Each	1	1.30	11077.54	**14400.80**	
Transportation Total:							**9533.26**
Transportation	☐	Mile	55	254.90	0.68	**9533.26**	
Vehicle Modifications Total:							**13142.22**
Vehicle Modifications	☐	Each	6	1.30	1684.90	**13142.22**	
Wellness Education Total:							**131626.05**
Wellness Education	☐	Month	4199	8.10	3.87	**131626.05**	

GRAND TOTAL:	**6979333.73**
Total: Services included in capitation:	
Total: Services not included in capitation:	6979333.73
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**775.48**
Services included in capitation:	
Services not included in capitation:	775.48
Average Length of Stay on the Waiver:	284

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**6854543.36**
Respite	☐	Hour	3595	60.80	31.36	**6854543.36**	
Occupational Therapy Total:							**149.01**
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and Language Services	☐	Hour	1	1.30	114.62	**149.01**	
Assistive Technology Total:							**100919.18**
Assistive Technology	☐	Each	175	0.70	823.83	**100919.18**	
Community Engagement Total:							**92911.95**
Community Engagement	☐	Hour	94	34.50	28.65	**92911.95**	
Environmental Adaptations Total:							**259154.49**
Environmental Adaptations	☐	Each	35	1.90	3897.06	**259154.49**	
Life Skills Total:							**100267.20**
Life Skills	☐	Hour	55	25.32	72.00	**100267.20**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**476.74**
Peer Mentoring	☐	Hour	8	2.60	22.92	**476.74**	
Person-Centered Plan Facilitation Total:							**18237.96**
Person-	☐					**18237.96**	

GRAND TOTAL:	**8383116.65**
Total: Services included in capitation:	
Total: Services not included in capitation:	8383116.65
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**931.46**
Services included in capitation:	
Services not included in capitation:	931.46
Average Length of Stay on the Waiver:	317

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Centered Plan Facilitation		Hour	20	11.70	77.94		
Remote Supports Total:							**34962.24**
Remote Supports	☐	Hour	4	922.00	9.48	**34962.24**	
Risk Assessment Total:							**2304.13**
Risk Assessment	☐	Each	1	1.30	1772.41	**2304.13**	
Skilled Nursing Total:							**4229.94**
Skilled Nursing	☐	Hour	2	55.25	38.28	**4229.94**	
Specialized Clothing Total:							**8868.70**
Specialized Clothing	☐	Each	32	1.30	213.19	**8868.70**	
Specialized Equipment and Supplies Total:							**470277.93**
Specialized Equipment and Supplies	☐	Each	789	0.90	662.27	**470277.93**	
Specialized Habilitation Total:							**0.00**
Specialized Habilitation	☐	Hour	0	25.32	72.00	**0.00**	
Stabilization Services - Crisis Diversion Bed Total:							**113535.63**
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	**113535.63**	
Stabilization Services - Life Skills Total:							**19670.40**
Stabilization Services - Life Skills	☐	Hour	20	13.66	72.00	**19670.40**	
Stabilization Services - Specialized Habilitation Total:							**0.00**
Stabilization Services - Specialized Habilitation	☐	Hour	0	13.66	72.00	**0.00**	

GRAND TOTAL:	**8383116.65**
Total: Services included in capitation:	
Total: Services not included in capitation:	8383116.65
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**931.46**
Services included in capitation:	
Services not included in capitation:	931.46
Average Length of Stay on the Waiver:	317

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Stabilization Services - Staff/Family Consultation Total:							**32212.80**
Stabilization Services - Staff/Family Consultation	☐	Hour	20	22.37	72.00	**32212.80**	
Staff/Family Consultation Total:							**62061.12**
Staff/Family Consultation	☐	Hour	33	26.12	72.00	**62061.12**	
Supported Parenting Total:							**1668.94**
Supported Parenting	☐	Hour	2	9.10	91.70	**1668.94**	
Therapeutic Adaptations Total:							**14400.80**
Therapeutic Adaptations	☐	Each	1	1.30	11077.54	**14400.80**	
Transportation Total:							**11332.61**
Transportation	☐	Mile	64	260.40	0.68	**11332.61**	
Vehicle Modifications Total:							**13142.22**
Vehicle Modifications	☐	Each	6	1.30	1684.90	**13142.22**	
Wellness Education Total:							**167221.15**
Wellness Education	☐	Month	5144	8.40	3.87	**167221.15**	

GRAND TOTAL:	**8383116.65**
Total: Services included in capitation:	
Total: Services not included in capitation:	8383116.65
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**931.46**
Services included in capitation:	
Services not included in capitation:	931.46
Average Length of Stay on the Waiver:	317

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**7999528.32**
Respite	☐	Hour	4049	63.00	31.36	**7999528.32**	
Occupational Therapy Total:							**149.01**
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and Language Services	☐	Hour	1	1.30	114.62	**149.01**	
Assistive Technology Total:							**119949.65**
Assistive Technology	☐	Each	208	0.70	823.83	**119949.65**	
Community Engagement Total:							**108987.46**
Community Engagement	☐	Hour	109	34.90	28.65	**108987.46**	
Environmental Adaptations Total:							**287603.03**
Environmental Adaptations	☐	Each	41	1.80	3897.06	**287603.03**	
Life Skills Total:							**102009.60**
Life Skills	☐	Hour	56	25.30	72.00	**102009.60**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**476.74**
Peer Mentoring	☐	Hour	8	2.60	22.92	**476.74**	
Person-Centered Plan Facilitation Total:							**18237.96**
Person-	☐					**18237.96**	

GRAND TOTAL:	**9765849.19**
Total: Services included in capitation:	
Total: Services not included in capitation:	9765849.19
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**1085.09**
Services included in capitation:	
Services not included in capitation:	1085.09
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Centered Plan Facilitation		Hour	20	11.70	77.94		
Remote Supports Total:							**34962.24**
Remote Supports	☐	Hour	4	922.00	9.48	**34962.24**	
Risk Assessment Total:							**2304.13**
Risk Assessment	☐	Each	1	1.30	1772.41	**2304.13**	
Skilled Nursing Total:							**4229.94**
Skilled Nursing	☐	Hour	2	55.25	38.28	**4229.94**	
Specialized Clothing Total:							**9145.85**
Specialized Clothing	☐	Each	33	1.30	213.19	**9145.85**	
Specialized Equipment and Supplies Total:							**603195.52**
Specialized Equipment and Supplies	☐	Each	1012	0.90	662.27	**603195.52**	
Specialized Habilitation Total:							**0.00**
Specialized Habilitation	☐	Hour	0	25.30	72.00	**0.00**	
Stabilization Services - Crisis Diversion Bed Total:							**113535.63**
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	**113535.63**	
Stabilization Services - Life Skills Total:							**19728.00**
Stabilization Services - Life Skills	☐	Hour	20	13.70	72.00	**19728.00**	
Stabilization Services - Specialized Habilitation Total:							**0.00**
Stabilization Services - Specialized Habilitation	☐	Hour	0	13.70	72.00	**0.00**	

GRAND TOTAL:	**9765849.19**
Total: Services included in capitation:	
Total: Services not included in capitation:	9765849.19
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**1085.09**
Services included in capitation:	
Services not included in capitation:	1085.09
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Stabilization Services - Staff/Family Consultation Total:							**32256.00**
Stabilization Services - Staff/Family Consultation	☐	Hour	20	22.40	72.00	**32256.00**	
Staff/Family Consultation Total:							**63941.76**
Staff/Family Consultation	☐	Hour	34	26.12	72.00	**63941.76**	
Supported Parenting Total:							**1668.94**
Supported Parenting	☐	Hour	2	9.10	91.70	**1668.94**	
Therapeutic Adaptations Total:							**14400.80**
Therapeutic Adaptations	☐	Each	1	1.30	11077.54	**14400.80**	
Transportation Total:							**13140.86**
Transportation	☐	Mile	72	268.40	0.68	**13140.86**	
Vehicle Modifications Total:							**13142.22**
Vehicle Modifications	☐	Each	6	1.30	1684.90	**13142.22**	
Wellness Education Total:							**202687.38**
Wellness Education	☐	Month	6090	8.60	3.87	**202687.38**	

GRAND TOTAL:	**9765849.19**
Total: Services included in capitation:	
Total: Services not included in capitation:	9765849.19
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**1085.09**
Services included in capitation:	
Services not included in capitation:	1085.09
Average Length of Stay on the Waiver:	350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(8 of 9)*

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**9152704.51**
Respite	☐	Hour	4504	64.80	31.36	**9152704.51**	
Occupational Therapy Total:							**149.01**
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and Language Services	☐	Hour	1	1.30	114.62	**149.01**	
Assistive Technology Total:							**138980.12**
Assistive Technology	☐	Each	241	0.70	823.83	**138980.12**	
Community Engagement Total:							**125051.52**
Community Engagement	☐	Hour	124	35.20	28.65	**125051.52**	
Environmental Adaptations Total:							**329691.28**
Environmental Adaptations	☐	Each	47	1.80	3897.06	**329691.28**	
Life Skills Total:							**105652.80**
Life Skills	☐	Hour	58	25.30	72.00	**105652.80**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**536.33**
Peer Mentoring	☐	Hour	9	2.60	22.92	**536.33**	
Person-Centered Plan Facilitation Total:							**19149.86**
Person-	☐					**19149.86**	

GRAND TOTAL:	**11176089.10**
Total: Services included in capitation:	
Total: Services not included in capitation:	11176089.10
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**1241.79**
Services included in capitation:	
Services not included in capitation:	1241.79
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Centered Plan Facilitation		Hour	21	11.70	77.94		
Remote Supports Total:							**34962.24**
Remote Supports	☐	Hour	4	922.00	9.48	**34962.24**	
Risk Assessment Total:							**2304.13**
Risk Assessment	☐	Each	1	1.30	1772.41	**2304.13**	
Skilled Nursing Total:							**4233.77**
Skilled Nursing	☐	Hour	2	55.30	38.28	**4233.77**	
Specialized Clothing Total:							**9423.00**
Specialized Clothing	☐	Each	34	1.30	213.19	**9423.00**	
Specialized Equipment and Supplies Total:							**735517.06**
Specialized Equipment and Supplies	☐	Each	1234	0.90	662.27	**735517.06**	
Specialized Habilitation Total:							**0.00**
Specialized Habilitation	☐	Hour	0	25.30	72.00	**0.00**	
Stabilization Services - Crisis Diversion Bed Total:							**113535.63**
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	**113535.63**	
Stabilization Services - Life Skills Total:							**20714.40**
Stabilization Services - Life Skills	☐	Hour	21	13.70	72.00	**20714.40**	
Stabilization Services - Specialized Habilitation Total:							**0.00**
Stabilization Services - Specialized Habilitation	☐	Hour	0	13.70	72.00	**0.00**	

GRAND TOTAL:	**11176089.10**
Total: Services included in capitation:	
Total: Services not included in capitation:	11176089.10
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**1241.79**
Services included in capitation:	
Services not included in capitation:	1241.79
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Stabilization Services - Staff/Family Consultation Total:							**33868.80**
Stabilization Services - Staff/Family Consultation	☐	Hour	21	22.40	72.00	**33868.80**	
Staff/Family Consultation Total:							**65822.40**
Staff/Family Consultation	☐	Hour	35	26.12	72.00	**65822.40**	
Supported Parenting Total:							**1668.94**
Supported Parenting	☐	Hour	2	9.10	91.70	**1668.94**	
Therapeutic Adaptations Total:							**14400.80**
Therapeutic Adaptations	☐	Each	1	1.30	11077.54	**14400.80**	
Transportation Total:							**14926.68**
Transportation	☐	Mile	81	271.00	0.68	**14926.68**	
Vehicle Modifications Total:							**15332.59**
Vehicle Modifications	☐	Each	7	1.30	1684.90	**15332.59**	
Wellness Education Total:							**236895.08**
Wellness Education	☐	Month	7036	8.70	3.87	**236895.08**	

GRAND TOTAL:	**11176089.10**
Total: Services included in capitation:	
Total: Services not included in capitation:	11176089.10
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**1241.79**
Services included in capitation:	
Services not included in capitation:	1241.79
Average Length of Stay on the Waiver:	350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**10292966.66**
Respite	☐	Hour	4958	66.20	31.36	**10292966.66**	
Occupational Therapy Total:							**149.01**
Occupational Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Physical Therapy Total:							**149.01**
Physical Therapy	☐	Hour	1	1.30	114.62	**149.01**	
Speech, Hearing and Language Services Total:							**149.01**
Speech, Hearing and Language Services	☐	Hour	1	1.30	114.62	**149.01**	
Assistive Technology Total:							**158010.59**
Assistive Technology	☐	Each	274	0.70	823.83	**158010.59**	
Community Engagement Total:							**140975.19**
Community Engagement	☐	Hour	139	35.40	28.65	**140975.19**	
Environmental Adaptations Total:							**371779.52**
Environmental Adaptations	☐	Each	53	1.80	3897.06	**371779.52**	
Life Skills Total:							**109296.00**
Life Skills	☐	Hour	60	25.30	72.00	**109296.00**	
Nurse Delegation Total:							**270.14**
Nurse Delegation	☐	Hour	1	5.20	51.95	**270.14**	
Peer Mentoring Total:							**536.33**
Peer Mentoring	☐	Hour	9	2.60	22.92	**536.33**	
Person-Centered Plan Facilitation Total:							**19149.86**
Person-	☐					**19149.86**	

GRAND TOTAL:	**12576957.58**
Total: Services included in capitation:	
Total: Services not included in capitation:	12576957.58
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**1397.44**
Services included in capitation:	
Services not included in capitation:	1397.44
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Centered Plan Facilitation		Hour	21	11.70	77.94		
Remote Supports Total:							**43702.80**
Remote Supports	☐	Hour	5	922.00	9.48	**43702.80**	
Risk Assessment Total:							**2304.13**
Risk Assessment	☐	Each	1	1.30	1772.41	**2304.13**	
Skilled Nursing Total:							**4233.77**
Skilled Nursing	☐	Hour	2	55.30	38.28	**4233.77**	
Specialized Clothing Total:							**9700.15**
Specialized Clothing	☐	Each	35	1.30	213.19	**9700.14**	
Specialized Equipment and Supplies Total:							**867838.61**
Specialized Equipment and Supplies	☐	Each	1456	0.90	662.27	**867838.61**	
Specialized Habilitation Total:							**0.00**
Specialized Habilitation	☐	Hour	0	25.30	72.00	**0.00**	
Stabilization Services - Crisis Diversion Bed Total:							**113535.63**
Stabilization Services - Crisis Diversion Bed	☐	Day	3	39.00	970.39	**113535.63**	
Stabilization Services - Life Skills Total:							**20714.40**
Stabilization Services - Life Skills	☐	Hour	21	13.70	72.00	**20714.40**	
Stabilization Services - Specialized Habilitation Total:							**0.00**
Stabilization Services - Specialized Habilitation	☐	Hour	0	13.70	72.00	**0.00**	

GRAND TOTAL:	**12576957.58**
Total: Services included in capitation:	
Total: Services not included in capitation:	12576957.58
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**1397.44**
Services included in capitation:	
Services not included in capitation:	1397.44
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Stabilization Services - Staff/Family Consultation Total:							**33868.80**
Stabilization Services - Staff/Family Consultation	☐	Hour	21	22.40	72.00	**33868.80**	
Staff/Family Consultation Total:							**67703.04**
Staff/Family Consultation	☐	Hour	36	26.12	72.00	**67703.04**	
Supported Parenting Total:							**1668.94**
Supported Parenting	☐	Hour	2	9.10	91.70	**1668.94**	
Therapeutic Adaptations Total:							**14400.80**
Therapeutic Adaptations	☐	Each	1	1.30	11077.54	**14400.80**	
Transportation Total:							**16721.68**
Transportation	☐	Mile	89	276.30	0.68	**16721.68**	
Vehicle Modifications Total:							**15332.59**
Vehicle Modifications	☐	Each	7	1.30	1684.90	**15332.59**	
Wellness Education Total:							**271800.94**
Wellness Education	☐	Month	7981	8.80	3.87	**271800.94**	

GRAND TOTAL:	**12576957.58**
Total: Services included in capitation:	
Total: Services not included in capitation:	12576957.58
Total Estimated Unduplicated Participants:	**9000**
Factor D (Divide total by number of participants):	**1397.44**
Services included in capitation:	
Services not included in capitation:	1397.44
Average Length of Stay on the Waiver:	350