TN Department of Intellectual & Developmental Disabilities

ATTACHMENT 4

SERVICE DEFINITIONS: 1915C

To be used for Reference during the Credentialing Process

RESIDENTIAL SERVICES:

Family Model Residential Support

Service Definition (Scope):

Family Model Residential Support shall mean a type of residential service selected by the person supported, where he or she lives in the home of a trained caregiver who is a not family member in an "adult foster care" arrangement.

A family member(s) of the persons supported shall not be reimbursed to provide Family Model Residential Support services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

In this type of shared living arrangement, the caregiver allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and family, supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and supports each resident in a manner that comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person- centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual.

Family Model Residential Support includes individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside successfully in a community-based setting, living in a family environment in the home of trained caregivers other than the family of origin.

Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community.

Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Family Model Residential Supports may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

The Family Model Residential Support caregiver shall oversee the health care needs of the person supported.

The Family Model Residential Support provider agency shall not find, purchase, or lease a residence in which Family Model Residential Supports will be provided.

Family Model Residential Support caregivers shall be recruited, screened, contracted, and trained prior to providing services, and monitored by the Family Model Residential Support provider

agency to ensure compliance with licensing and program requirements.
The Family Model Residential Support provider agency shall facilitate matching of persons supported and caregivers but shall not determine whether a caregiver chooses to participate in the program, whether a caregiver will bring a particular person supported into his or her home, or how the day-to-day activities of the home and provision of services and supports will occur.
Visits, both announced and unannounced, and phone calls to the home must occur on a regular basis in order for the provider agency to ensure compliance with program requirements and the general health and safety of the person supported, but should not be so prescriptive as to instruct the provider about particular tasks to perform or ways to fulfill or not fulfill duties.
Family Model Support caregivers are responsible for abiding by the quality assurance standards, outlined in the DIDD Provider Manual, which are monitored and enforced by DIDD.
A Family Model Residential Support home shall have no more than 3 residents who receive services and supports regardless of HCBS program or funding source.
The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports for up to 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work, based on the person's support needs.
Persons supported should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk.
Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule.
With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such.
Family Model Residential Support shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).
Reimbursement for Family Model Residential Support shall not include payment for Family Model Residential Support provided by the spouse of a person supported.
The Family Model Residential Support provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Family Model Residential Support provided by such individuals.
Reimbursement for Family Model Residential Support shall not include payment made to any other individual who is a conservator, unless so permitted in the Order for Conservatorship.
Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling.
Family Model Residential Support may be provided out-of-state under the following circumstances:

a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.

b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-

state services is at the discretion of the service provider).

c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

The Residential Special Needs Adjustment – Homebound (RSNA-HB) is a supplementary per diem payment that may be approved in limited circumstances as specified herein for Family Model Residential Support service that are provided in the individual's residence when the individual is determined by TennCare and DIDD to meet the definition of 'homebound" and as a result, is unable (not unwilling) to participate in any employment or day service and must remain at their residence for the full 24 hours of a particular day, except leaving the home for medical treatment or medical appointments, and requires paid support in the residence during that time. 'Homebound' is defined as being unable (not unwilling) to leave your home except for medical treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day (the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period.

RSNA-HB can only be authorized and paid in limited exceptional circumstances when engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to:

1. Needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.
2. Needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.
3. Needs related to recovery after a period of hospitalization, recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.
4. Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the individual's health and physical well-being.

RSNA-HB payments are intended to be as time-limited as possible, with a goal of supporting the individual to engage in employment or other integrated community activities and must be reviewed and reauthorized, as appropriate, at a minimum, every 90 days, and not on a continuous basis, except in exceptional circumstances as approved by TennCare and DIDD (e.g., end of life). All individual goals and objectives, and specific needed supports, related to authorization of the RSNA-HB, and to supporting the individual's ability to participate in employment and other integrated community activities shall be established through the person-centered planning process and documented in the person-centered ISP. The RSNA-HB can only be authorized and paid for services

provided on the same day that Family Model Residential Support service is also authorized and provided.

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

A person authorized to receive the RSNA-HB payment may receive therapy services such as PT, OT, Speech, Language and Hearing, and Behavior Services on the same day the RSNA-HB payment is made when appropriate based on the individualized needs and goals of the person supported. A person authorized to receive the RSNA-HB payment may receive Nursing Services only on an intermittent basis and limited to no more than one hour of the six-hour period to perform specific skilled nursing tasks that cannot be performed by or delegated to the staff providing the residential service for which the RSNA-HB is authorized. If a person receives continuous nursing, the RNSA-HB payment shall not be paid. The RSNA- HB does not replace any of the existing residential special needs adjustments. It can be authorized in addition to another residential special needs adjustment that is authorized for a different, non- duplicative purpose on same day. The RSNA-HB payment shall not be provided on any day that the person supported receives any Employment or Day Services, services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego. It may not be self-directed. The RNSA-HB payment will become available in qualifying circumstances beginning April 1, 2019 or a subsequent date by which IT changes necessary to implement this waiver amendment are complete.

License (specify):

Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Placement Service provider.

Other Standard (specify):

Please see below.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Medical Residential Services

Service Definition (Scope):

Medical Residential Services shall mean a type of residential service selected by the person supported, encompassing the provision of direct skilled nursing services and habilitative services and supports that enable a person supported to acquire, retain, or improve skills necessary to reside in a community-based setting, and which supports each resident's independence and full integration into the community, ensures each resident's choice and rights. and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP. All individual goals and objectives, along with needed supports shall be established through the person- centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual.

Medical Residential Services must be medically necessary and provided in accordance with the person- centered ISP.

The person supported who receives Medical Residential Services must have a medical diagnosis and treatment needs that would justify the provision of direct skilled nursing services that must be provided directly by a registered nurse or a licensed practical nurse, and such services must be needed on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits and which cannot be more cost-effectively provided through a combination of waiver services and other available services.

There must be an order by a physician, physician assistant, or nurse practitioner for one or more specifically identified skilled nursing services, excluding nursing assessment or oversight, that must be provided directly by a registered nurse or by a licensed practical nurse in accordance with the Tennessee Nurse Practice Act.

The Medical Residential Services provider may elect to have the Nurse also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the individual during the period that Medical Residential Services are authorized and provided, unless such assistance cannot be safely provided by the nurse while also attending to the individual's skilled nursing needs. However, the need for Medical Residential services shall depend only on the skilled nursing needs of the individual.

Medical Residential services shall be provided in an appropriately licensed Residential Habilitation or Supported Living home.

The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports, including skilled nursing services, up to 24 hours per day 7 days a week when the person supported is not at school or participating in individualized integrated employment, based on the individualized needs of each resident; however, a nurse is not required to be present in the home during those time periods when skilled nursing services are not medically necessary.

One nurse can provide services to more than one person supported in the home during the same

time period if it is medically appropriate to do so.
The Medical Residential Services provider shall be responsible for the cost of all Day Services other than Supported Employment - Individual Employment Support (including Community Participation Supports, Facility-Based Day Support Services, Supported Employment- Small Group, and Intermittent Employment and Community Participation Wraparound supports) needed by the person supported and any skilled nursing services needed while receiving Day Services.
In order to promote and incentivize participation in individualized integrated employment, a person receiving Medical Residential Services may also receive the Supported Employment-Individual Employment Support, and the provider shall not be responsible for the cost of this service.
Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community.
Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.
Medical Residential Services may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.
The Medical Residential provider shall oversee the health care needs of the person supported.
A Medical Residential Services home shall have no more than 4 residents with the exception of those homes which were licensed as a Residential Habilitation Facility prior to July 1, 2000.
Individuals receiving Medical Residential services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.
Medical Residential Services shall not be provided in schools or in institutional settings (e.g., inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities).
Medical Residential Services shall not be provided in a home where a person supported lives with family members unless such family members are also HCBS persons supported.
Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.
Since the Medical Residential Services provider is responsible for providing direct support and other services up to 24 hours per day 7 days per week when the person supported is not at school or participating in individualized integrated employment, based on a person's support needs, a person supported who is receiving Medical Residential Services shall not be eligible to receive Personal Assistance, Community Participation Supports, Facility-Based Day Support Services, Supported Employment- Small Group, Intermittent Employment and Community Participation Wraparound supports, or Respite.
Persons supported should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk.

Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule.
Medical Residential Services are not intended to replace services available through the Medicaid State Plan/TennCare Program.
With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such.
Reimbursement for Medical Residential Services shall not be made for room and board or for the cost of maintenance of the dwelling if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the person supported, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated
to the person supported and who provides services to the person supported in the place of residence of the person supported.
If a person supported owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person supported, other residents in the home, and (as applicable) live-in or other caregivers.
Reimbursement for Medical Residential Services shall not include payment made for services provided by an individual who has been appointed as the conservator of the person supported, unless so permitted in the Order for Conservatorship.
Reimbursement for Medical Residential Services shall not include payment for Medical Residential Services provided by the spouse of a person supported.
The Medical Residential Services provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Medical Residential Services provided by such individuals.
Medical Residential Services may be provided out-of-state under the following circumstances:

a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.
b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.
d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A person receiving Medical Residential Services shall not be eligible to receive the Residential Special Needs Adjustment – Homebound.
License (specify):
Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as Intellectual Disability/Developmental Disability Residential Habilitation Facility provider or a Supported Living Provider and ensure that employed nurses are licensed to practice in the state of Tennessee (TDH 1370-1).
Other Standard (specify):
Please see below.
The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Residential Habilitation

Service Definition (Scope):

Residential Habilitation shall mean a type of residential service selected by the person supported, offering individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a community-based setting and which supports each resident's independence and full integration into the community, and ensures each resident's choice and rights.

Residential Habilitation services shall be provided in a dwelling which may be rented, leased, or owned by the Residential Habilitation provider, and shall comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person- centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the person supported.

Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation, household chores) essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community.

Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. Residential Habilitation may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

The Residential Habilitation provider shall oversee the person's health care needs. The Residential Habilitation dwelling shall be licensed by the State of Tennessee.

A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so .Individuals receiving Residential Habilitation services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted pursuant to state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports for up to 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work, based on the person's support needs.

Persons supported should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk.

Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule.
A person supported who is receiving Residential Habilitation shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Residential Habilitation provider).
With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, and in accordance with TennCare protocol, transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such.
Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling.
Reimbursement for Residential Habilitation shall not include payment for Residential Habilitation provided by the spouse of a person supported. The Residential Habilitation provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Residential Habilitation provided by such individuals.
Reimbursement for Residential Habilitation shall not include payment made for services provided by an individual who has been appointed as the conservator of the person supported, unless so permitted in the Order for Conservatorship.
This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).
Residential Habilitation shall not be provided in a home where a person supported lives with family members unless such family members are also persons supported. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.
Residential Habilitation may be provided out-of-state under the following circumstances:

a. Out-of-state services shall be limited to a maximum of 14 days per person supported per waiver program year (i.e. calendar year).

b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).

c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

The Residential Special Needs Adjustment – Homebound (RSNA-HB) is a supplementary per diem payment that may be approved in limited circumstances as specified herein for Residential Habilitation services that are provided in the individual's residence when the individual is determined by TennCare and DIDD to meet the definition of 'homebound" and as a result, is unable

(not unwilling) to participate in any employment or day service and must remain at their residence for the full 24 hours of a particular day, except leaving the home for medical treatment or medical appointments, and requires paid support in the residence during that time. 'Homebound' is defined as being unable (not unwilling) to leave your home except for medical treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day (the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period.

RSNA-HB can only be authorized and paid in limited exceptional circumstances when engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to:

1. Needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.
2. Needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.
3. Needs related to recovery after a period of hospitalization, recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.
4. Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the individual's health and physical well-being.

RSNA-HB payments are intended to be as time-limited as possible, with a goal of supporting the individual to engage in employment or other integrated community activities and must be reviewed and reauthorized, as appropriate, at a minimum, every 90 days, and not on a continuous basis, except in exceptional circumstances as approved by TennCare and DIDD (e.g., end of life).

All individual goals and objectives, and specific needed supports, related to authorization of the RSNA- HB, and to supporting the individual's ability to participate in employment and other integrated community activities shall be established through the person-centered planning process and documented in the person-centered ISP.

The RSNA-HB can only be authorized and paid for services provided on the same day that Residential Habilitation services are also authorized and provided.

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

A person authorized to receive the RSNA-HB payment may receive therapy services such as PT, OT, Speech, Language and Hearing, and Behavior Services on the same day the RSNA-HB payment is made when appropriate based on the individualized needs and goals of the person supported.

A person authorized to receive the RSNA-HB payment may receive Nursing Services only on an intermittent basis and limited to no more than one hour of the six-hour period to perform specific skilled nursing tasks that cannot be performed by or delegated to the staff providing the residential service for which the RSNA-HB is authorized. If a person receives continuous nursing, the RNSA-HB payment shall not be paid.

The RSNA- HB does not replace any of the existing residential special needs adjustments. It can be authorized in addition to another residential special needs adjustment that is authorized for a different, non-duplicative purpose on same day.

The RSNA-HB payment shall not be provided on any day that the person supported receives any Employment or Day Services, services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego. It may not be self- directed.
The RNSA-HB payment will become available in qualifying circumstances beginning April 1, 2019 or a subsequent date by which IT changes necessary to implement this waiver amendment are complete.
License (specify):
Waiver service agency - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility.
Other Standard (specify):
Please see below.
The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Semi-Independent Living Services (SILS)

Service Definition (Scope):

Semi-Independent Living Services (SILS) shall mean services selected by the person supported that include training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene, interpersonal and social skills building, and other activities needed to maintain and improve the capacity of an individual with an intellectual disability to live in the community, and which supports the person's independence and full integration into the community, ensures the person's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual's specific assessed need and set forth in the person-centered Individual Support Plan (ISP).

The service also includes oversight and assistance in managing self-administered medication and/or medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

The SILS provider shall oversee the health care needs of the person supported.

This service is appropriate for people who need intermittent or limited support to remain in their own home and do not require staff that lives on-site. However, access to emergency supports as needed from the provider on a 24/7 basis is an essential component of this residential service and is what differentiates it from Personal Assistance services.

Individuals receiving SILS may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home. No more than 3 persons receiving services will be permitted per residence.

All individual goals and objectives, along with needed supports shall be established through the person- centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual.

Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

The Circle of Support must consider the person's level of independence and safety prior to establishing a semi-independent living arrangement. Safety considerations must be reviewed at least annually (and more often should a change of needs or circumstances warrant). Consideration regarding the use of a Personal Emergency Response System should be given when appropriate.

The ISP must reflect the routine supports that will be provided by residential staff. The person may choose to live with one or two other persons supported and share expenses or to live alone as long as sufficient financial resources are available to do so.

Reimbursement for SILS shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person(s) supported and other residents in the home (if applicable).

A person who is receiving SILS shall not be eligible to receive Personal Assistance, Respite or Transportation as separate services. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of SILS and shall be included in the reimbursement rate for such.

The SILS provider shall not own the person’s place of residence or be a co-signer of a lease on the person’s place of residence unless the provider signs a written agreement with the person that states that the person will not be required to move if the primary reason is because the person desires to change to a different provider.

The SILS provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person to move if the person desires to change to a different provider.

SILS shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/IID). A family member(s) of the person supported shall not be reimbursed to provide SILS.

SILS shall not be provided in a home where a person supported lives with family members unless such family members are also persons receiving waiver services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

On a case-by-case basis, the DIDD Commissioner or designee may authorize SILS for a person supported who resides with his or her spouse and or minor children.

SILS shall not be provided out-of-state. A minimum of two face-to-face direct service visits in the home per week are required for each person receiving SILS. However, providers delivering this service are required to implement provisions for availability of provider staff on a 24-hour basis in case emergency supports are needed.

SILS providers are required to be licensed as Mental Retardation (i.e., Intellectual Disabilities) Semi-Independent Living Providers.

For individuals who are transitioning from a 24-hour residential waiver service supports into SILS and need additional hours of support during the transition period, providers will be reimbursed at a transition period rate, per the waiver max fee schedule, for a period of no more than 30 days from the date of transition.

For persons supported successfully transitioned from a 24-hour residential waiver service into Semi- Independent Living, a one-time per person "Transition to Independent Living Payment" will be made to the provider after the person supported has spent 6 consecutive months in SIL, so long as the person is still in SIL at the time of billing and is expected to continue living successfully in this setting. The "Transition to Independent Living Payment" will not count against a person's individual cost neutrality cap but will be included in all federally required demonstrations of waiver cost neutrality.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A person receiving Semi-Independent Living Services shall not be eligible to receive the Residential Special Needs Adjustment - Homebound or the Non-Residential Homebound Support Services.

License (specify):

Must be licensed by the Department of Intellectual and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation (i.e. Intellectual Disability) Semi-Independent Living Provider.

Other Standard (specify):

Please see below.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Division of Intellectual Disabilities Services.
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Supported Living (SL)

Service Definition (Scope):

Supported Living (SL) shall mean a type of residential service selected by the person supported having individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a home that is owned or leased by the residents and which supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered Individual Support Plan (ISP).

All individual goals and objectives, along with needed supports shall be established through the person- centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual.

Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation(excluding cost of food), household chores essential to the health and safety of the person, budget management(which shall include supporting the person in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person to live in a home in the community.

Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Supported Living may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

The SL provider shall oversee the health care needs of the person.

The Supported Living provider shall not own the place of residence of the person or be a co-signer of a lease on the place of residence of the person unless the SL provider signs a written agreement with the person that states that the person will not be required to move if the primary reason is because the person desires to change to a different SL provider.

A SL provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place

of residence to a person supported if such entity requires, as a condition of renting or leasing, the person to move if the SL provider changes.

The person(or the parent, guardian, or conservator acting on behalf of the person supported) shall have a voice in choosing the individuals who reside in the SL residence and the staff who provide services and supports.

A SL home shall have no more than 3 residents including the person supported. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must pass a home inspection approved by the State Medicaid Agency.

The Supported Living provider shall be responsible for providing an appropriate level of services and supports up to 24 hours per day during the hours the person is not receiving Day Services, is not otherwise engaged with natural supports, is not at school or work, based on the person's support needs.

Persons should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk.

Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule.

Thus, a person supported who is receiving SL shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the SL provider).

Supported Living shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

Supported Living shall not be provided in a home where a person lives with family members unless such family members also receive SL services, or by special exception when the family member is a minor child living with a parent receiving services or spouse of a person receiving services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption. In

Supported Living companion model, family and friends of the companion staff may only reside in the home of the person supported when approved by the person or his/her conservator. Such approval shall be documented in the person-centered ISP.

Individuals receiving Supported Living services may choose to receive services in a shared living

arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.
Supported Living shall not be covered for persons supported under age 18 years. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such.
Reimbursement for Supported Living shall not include payment for Supported Living provided by the spouse of a person supported. The Supported Living provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Supported Living provided by such individuals.
Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the person supported and who provides services to the person supported in the home of the person supported.

Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling.

Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person supported, other residents in the home, and (as applicable) live-in or other caregivers.

For Supported Living services in a companion model home, all U.S. Department of Labor, Wage and Hour Division rules shall be applied to live-in caregivers.

Supported Living may be provided out-of-state under the following circumstances:
a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.
b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider

qualifications.

d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

e. The Residential Special Needs Adjustment – Homebound (RSNA-HB) is a supplementary per diem payment that may be approved in limited circumstances as specified herein for Supported Living service that are provided in the individual's residence when the individual is determined by TennCare and DIDD to meet the definition of 'homebound" and as a result, is unable (not unwilling) to participate in any employment or day service and must remain at their residence for the full 24 hours of a particular day, except leaving the home for medical treatment or medical appointments, and requires paid support in the residence during that time. 'Homebound' is defined as being unable (not unwilling) to leave your home except for medical treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day (the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period.

RSNA-HB can only be authorized and paid in limited exceptional circumstances when engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to:

1. Needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.

2. Needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.

3. Needs related to recovery after a period of hospitalization, recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.

4. Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise

the person's health and physical well-being. RSNA-HB payments are intended to be as time-limited as possible, with a goal of supporting the person to engage in employment or other integrated community activities and must be reviewed and reauthorized, as appropriate, at a minimum, every 90 days, and not on a continuous basis, except in exceptional circumstances as approved by TennCare and DIDD(e.g., end of life). All individual goals and objectives, and specific needed supports, related to authorization of the RSNA-HB, and to supporting the individual's ability to participate in employment and other integrated community activities shall be established through the person-centered planning process and documented in the person- centered ISP. The RSNA-HB can only be authorized and paid for services provided on the same day that SL service is also authorized and provided.

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

A person authorized to receive the RSNA-HB payment may receive therapy services such as PT, OT, Speech, Language and Hearing, and Behavior Services on the same day the RSNA-HB payment is made when appropriate based on the individualized needs and goals of the person supported. A person authorized to receive the RSNA-HB payment may receive Nursing Services only on an intermittent basis and limited to no more than one hour of the six-hour period to perform specific skilled nursing tasks that cannot be performed by or delegated to the staff providing the residential service for which the RSNA-HB is authorized. If a person receives continuous nursing, the RNSA-HB payment shall not be paid. The

RSNA- HB does not replace any of the existing residential special needs adjustments. It can be authorized in addition to another residential special needs adjustment that is authorized for a different, non- duplicative purpose on same day. The RSNA-HB payment shall not be provided on any day that the person supported receives any Employment or Day Services, services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego. It may not be self-directed. The RNSA-HB payment will become available in qualifying circumstances beginning April 1, 2019 or a subsequent date by which IT changes necessary to implement this waiver amendment are complete.

License (specify):
Individual-Must be licensed by the Department of Intellectual and Developmental Disabilities as a Supported Living Service Provider, if serving more than one person.

Other Standard (specify):
Please see below.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.

4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

DAY & EMPLOYMENT SERVICES

Community Participation Supports

Service Definition (Scope):

Community Participation Supports are services which coordinate and/or provide supports for valued and active participation in integrated community opportunities that build on the person's interests, preferences, gifts, and strengths while reflecting the person's goals with regard to community involvement and membership. This service involves participation in one or more integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers.
Community Participation Supports are designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and goals for community involvement and participation. Community Participation Supports enable the person to increase or maintain his/her capacity for independent participation in community life and to develop age-appropriate social roles valued by the community by learning, practicing and applying skills necessary for full inclusion in the person's community, including skills in arranging and using public transportation for individuals aged 16 or older.

Community Participation Supports provide assistance for active and positive participation in a broad range of integrated community settings that allow the person to engage with people who do not have disabilities who are not paid or unpaid caregivers. The service is expected to result in the person developing and sustaining a range of valued, age-appropriate social roles and relationships; building natural supports; increasing independence; and experiencing meaningful community integration and inclusion.

Activities are expected to increase the individual's opportunity to build connections within his/her local community and include (but are not limited to) the following:
o Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks with community organizations and clubs to;
o Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, walking group, etc.); o Supports to participate in adult education and postsecondary education classes;
o Supports to participate in formal/informal associations or community/neighborhood groups; o Supports to participate in volunteer opportunities;
o Supports to participate in opportunities focused on training and education for self-

determination and self-advocacy; Supports for learning to navigate the local community, including learning to use public transportation and/or private transportation available in the local area;

o Supports to maintain relationships with members of the broader community (e.g. neighbors, co- workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.

This service includes a combination of training and supports as needed by the individual. The Community Participation Supports provider shall be responsible for any personal assistance needs during the hours that Community Participation Supports are provided; however, the personal assistance services may not comprise the entirety of the Community Participation Supports.

This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve his or her personally identified goals for community integration, involvement, exploration and for developing and sustaining a network of positive natural supports. All settings where Community Participation Supports are provided must be non-disability specific and meet all federal standards for HCBS settings. This service is provided separate and apart from the person's place of residence. This service does not take place in licensed facilities, sheltered workshops or any type of facility owned, leased or operated by a provider of this service.

An individual's person-centered support plan may include more than one non-residential habilitation service (Supported Employment-Individual Employment Supports; Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around Supports; Facility-Based Day Supports); however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

Transportation during the provision of these services is included in the rates paid for these services. Transportation of a participant to and from these services is included in the rates paid for these services when such transportation is needed by a participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Non-residential habilitation services (Supported Employment-Individual Employment Supports (except as noted below); Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around

Supports; Facility-Based Day Supports) and either the Residential Special Needs Adjustment-Homebound or the Non-Residential Homebound Support Service, when combined, may involve no more than 5,832 quarter hour units/year and no more than 240 quarter hour units in a fourteen day billing period. The Residential Special Needs Adjustment-Homebound and the Non-Residential Homebound Support Service are paid on a per diem basis and each day shall be considered as 24 quarter hour units for the purposes of including this service in the annual and billing period limits. Under Supported Employment-Individual Employment Supports, authorizations of Exploration, Discovery and Job Development are not included in these limits.

Community Participation and Supports shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego. Except for students who have graduated prior to May of 2014, Day Services for school aged persons (i.e., under the age of 22) are limited to regular school break periods.

This service is available beginning January 1, 2020.

License (specify):
Must hold an Intellectual Disability Community-Based Adult Habilitation Day license from the Department of Intellectual and Developmental Disabilities.

Other Standard (specify):
Please see below.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Intermittent Employment & Community Integration Wrap-Around Supports

Service Definition (Scope):

These supports are expressly designed to support waiver participants in engaging in integrated community participation and integrated community employment when sustained, all-day participation in these opportunities outside the home is not possible for the individual due to intermittent needs related to personal care (where this care requires certain environments and/or equipment to perform, which is not otherwise available to the individual in any integrated community setting), personal assistance with preparing and eating a meal, and/or regaining stamina (physical and mental readiness and/or motivation for integrated community participation and/or employment occurring later on the same day). This service is also expressly designed to avoid the need for people to attend a facility-based day service setting in order to have these intermittent needs met, and to enable people with these needs to use their home as the base from which they routinely access their neighborhood and broader community. On each day this service is delivered, the service includes supports and supervision that are appropriate and necessary to enable a waiver participant, who has engaged in integrated employment and/or community participation earlier in the day, to engage in additional integrated employment and/or community participation later in the day. The focus of the supports is facilitating the development of skills for activities of daily living and community living, including enabling the person to attain or maintain his/her maximum potential for engagement in integrated employment and community participation.

This service may be delivered by the waiver participant's residential provider or by the waiver participant's chosen provider of other non-residential habilitation services occurring on the same day (or one of these providers if more than one is providing services to the waiver participant in a given day) in order to ensure seamless continuity of supports for a waiver participant being supported with community participation and/or integrated employment. An individual's person-centered support plan may include more than one non-residential habilitation service (Supported Employment-Individual Employment Supports; Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around Supports; Facility-Based Day Supports); however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

Transportation during the provision of these services is included in the rates paid for these

services. Transportation of a participant to and from these services is included in the rates paid for these services when such transportation is needed by a participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Non-residential habilitation services (Supported Employment-Individual Employment Supports (except as noted below); Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around Supports; Facility-Based Day Supports) and either the Residential Special Needs Adjustment-Homebound or the Non-Residential Homebound Support Service, when combined, may involve no more than 5,832 quarter hour units/year and no more than 240 quarter hour units in a fourteen day billing period. The Residential Special Needs Adjustment-Homebound and the Non-Residential Homebound Support Service are paid on a per diem basis and each day shall be considered as 24 quarter hour units for the purposes of including this service in the annual and billing period limits. Under Supported Employment-Individual Employment Supports, authorizations of Exploration, Discovery and Job Development are not included in these limits.

In authorizing Intermittent Employment and Community Integration Wrap-Around Supports, units authorized shall be counted for the purposes of implementing the overall annual and billing period limit in (1.) above but Intermittent Employment and Community Integration Wrap-Around Supports shall be limited to no more than 160 quarter hour units in a 14 day billing period and no more than 3,888 quarter hour units/year limit. A waiver participant may receive this service up to four (4) hours on same day that at least two (2) hours of Supported Employment (Individual and/or Small Group) and/or Community Participation Supports are also provided (or the waiver participants spends at least two (2) hours working in the community and/or participating in the community without staff support because the staff support is not necessary). The two (2) hours of Supported Employment (Individual and/or Small Group) and/or Community Participation Supports (or the two hours the waiver participant spends working in the community and/or participating in the community without staff support because the staff support is not necessary) may or may not be consecutive hours. On a given day, home-based supports that are needed in excess of four (4) hours are considered to be the responsibility of the residential provider. In the case of a waiver participant that lives with the family, this is considered to be the responsibility of the family or covered by Personal Assistance authorization. Further, the amount of units authorized shall in all cases be limited based on documented needs of the individual and shall not be authorized for the purposes of supplementing other non-residential habilitation services up to the maximum hours of service allowable if there is not a documented need for this amount of service. These supports are designed to address intermittent needs which will vary by individual waiver participant.

Intermittent Employment and Community Integration Wrap-Around Supports shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego. Except for students who have graduated prior to May of 2014, Day Services for school aged persons (i.e., under the age of 22) are limited to regular school break periods. The Intermittent Employment and Community Integration Wrap-Around Support service may not be provided on the same date as Facility-Based Day Supports. This service is available beginning January 1, 2020.

License (specify):
If serving more than one individual waiver participant, must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Adult Habilitation Day Facility (TCA Title 33 Chapter 2).

Other Standard (specify):
Please see below.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Non-Residential Homebound Support Services

Service Definition (Scope):

Non-Residential Homebound Support Services shall mean a type of service offering individualized services and supports that enable the person to avoid institutionalization and live in the community in a non-residential setting of their choice, typically the family home or the individual's own home. Non- Residential Homebound Support Services shall be delivered in a manner that aligns with the individual's specific assessed need as set forth in the person-centered ISP.

Non-Residential Homebound Support Services is a per diem service that is provided in the individual's residence when the individual is determined to be homebound on a particular day and unable to leave their home. 'Homebound' is defined as being unable to leave your home for at least 2 hours per day for a sustained period of time which is at least 5 days in a 14-day billing period. (The 2 hours may or may not be consecutive). The Non-Residential Homebound Support Services per diem may be authorized to support waiver participants when they meet the definition of 'homebound' and therefore are unable to participate in an employment or day service and need to remain at their residence for the full twenty- four hours of the day, except leaving the home for medical treatment or medical appointments.

The intent of the Non-Residential Homebound Support Service is that it be authorized on an as needed basis, not on a continuous basis unless justified (e.g. end-of-life circumstances or prolonged serious illness). The service is authorized on a per diem basis and can be authorized in addition to personal assistance quarterly units; however, the two services shall not be provided or reimbursed at the same time. Non-Residential Homebound Support Services shall not be provided or paid on any day when any other employment or day service is provided. Non-Residential Homebound Support Services shall not be provided at the same time as any other Waiver services, provided that therapy services (Physical Therapy, Occupational Therapy, Speech, Language and Hearing) and Behavior Services may be provided while a person is receiving Non-Residential Homebound Support Services when appropriate based on the individualized needs and goals of the person supported. Nursing Services may be provided at the time as the Non-Residential Homebound Support Service only on an intermittent basis and limited to no more than one hour to perform specific skilled nursing tasks that cannot be performed by or delegated to the staff providing the Non-Residential Homebound Support Service. When Nursing Services are provided for a longer period, the nurse shall also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the person supported during the period that

Nursing Services are authorized and provided. The Non-Residential Homebound Support Service per diem is to be used only on days, beyond the first four (4) days in any 14-day billing period that the individual is considered 'homebound', when the person cannot go out of their house for the entire twenty-four hour period due to their circumstances, except leaving the home for medical treatment or medical appointments.

For an individual to be eligible for the Non-Residential Homebound Support Service, the person is unable to leave his/her home for at least 2 hours per day (hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period, due to one or more of the following criteria:

1. Engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.
2. Engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.
3. Engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to needs related to recovery after a period of hospitalization (e.g. discharge after surgery), recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.
4. Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the individual's health and physical well-being.

Non-Residential Homebound Support Service is only used in the above exceptional circumstances and is to be used only as needed and only on days when the above criteria are applicable. Authorizations for Non-Residential Homebound Support Service are to be reviewed and reauthorized, as appropriate, every 90 days.

All individual goals and objectives, and specific needed supports, related to authorization of the Non- Residential Homebound Support Service shall be established through the person-centered planning process and documented in the person-centered ISP. Supports may include of direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, meal preparation excluding cost of food, toileting and incontinence care, assistance with transfer and mobility), and household chores essential to the health and safety of the person supported (e.g., washing dishes; personal laundry; general housecleaning in areas of the residence used by the person supported). Supports shall be provided in a manner which ensures an individual's rights of privacy,dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

The Non-Residential Homebound Support Service may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Non-Residential Homebound Support Service per diem requires a minimum of six (6) hours of service to be delivered on the day for which it is billed. The six (6) hours of service may be provided during the day or night, as specified in the person-centered ISP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A person supported who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive the Non- Residential Homebound Support Service. A person receiving Semi-Independent Living Services shall not be eligible to receive the Non-Residential Homebound Support Service.

The Non-Residential Homebound Support Service shall not be provided during the same time period that the person supported is receiving, Personal Assistance, other Day Services, Respite Services, services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The Non-Residential Homebound Support Service shall not be provided in a licensed facility (e.g., a group home, boarding home, or assisted living home).

The Non-Residential Homebound Support Service shall be limited to a maximum of 10 days in a 14-day billing period The Non-Residential Homebound Support Service shall be limited to a maximum of 10 days in a 14-day billing cycle.

The service cannot be billed until the homebound requirement is met—unable to participate in any employment or day service OR to leave the home except for medical treatment or medical appointments and for at no more than 2 hours a day for at least 5 days in the billing period.

The service cannot be billed on any day when any other employment or day service is provided. Each day will be treated as twenty-four (24) quarter hour units for the purposes of including this service in the two- hundred forty (240) quarter-hour units cap on combined employment and day services in each 14-day billing period. The Non-Residential Homebound Support Service shall be limited to a maximum of 243 days per person per calendar year. Each day will be treated as twenty-four (24) quarter hour units for the
purposes of including this service in the five-thousand eight-hundred thirty-two (5,832) quarter-hour units cap on combined employment and day services per year.

The Non-Residential Homebound Support Service may not be self-directed.

This service is available beginning January 1, 2020.

License (specify):
Must hold a PSSA license from the Department of Intellectual and Developmental Disabilities or Department of Mental Health or hold an Intellectual Disability Community-Based Adult Habilitation Day license from the Department of Intellectual and Developmental Disabilities.
Other Standard (specify):
Please see below.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a

criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).

5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.

6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Supported Employment-Individual Employment Support

Service Definition (Scope):

Services provided to a person who, because of his or her disabilities, needs support not available to the person through a program funded under Sec. 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) to obtain, maintain and/or advance in competitive integrated employment, including customized or self-employment, for which the individual is compensated at or above minimum wage. The expected outcome of these services is individualized integrated employment (IIE) or selfemployment (SE), consistent with the individual's personal and career goals, and defined as follows: 1) Sustained paid employment in a competitive or customized job with an employer for which an individual is compensated at or above the state's minimum wage, with the optimal goal being not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities; 2) Sustained paid SE that is home-based or conducted in an integrated setting(s) where net income in relation to hours worked is equivalent to no less than minimum wage, after a one-year start-up period. The Supported Employment—Individual Employment Support (SE-IES) provider shall be responsible for any Personal Assistance (PA) needs during the time that SE-IES services are provided; however, PA may not comprise the entirety of the SE-IES service(s) being provided. Transportation during the provision of these services is included in the rates paid for these services. Transportation of the individual to and from these services is included in the rates paid for these services when such transportation is needed by a participant. Time spent transporting the individual to/from the job site, when needed, in individual job coaching (JC) is considered authorized service time and it is expected that the job coach will use this time with the individual, as needed, to engage in conversation to identify/address employment-related issues and questions, and to provide support, guidance and positive reinforcement that contributes to the individual maintaining competitive integrated employment. An individual's Individual Support Plan may include more than one non-residential habilitation service (SE-IES; Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around Supports; Facility-Based Day Supports); however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time). A provider of SE-IES services may also receive Social Security's Ticket to Work Outcome and Milestone payments. These payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided. Attachment 4 1915c Page 40 of 88 SE-IES services are individualized and may include one or more of the following components: 1. Exploration: This is a time-limited and targeted service designed to help a person make an informed choice about whether s/he wishes to pursue IIE or SE, as defined above. This service is not appropriate for Waiver participants who already know they want to pursue IIE or SE. This service includes career exploration activities to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to IIE or SE This service also includes exploration of IIE or SE opportunities in the local area that are specifically related to the person's identified interests, experiences and/or skills through four to five uniquely arranged business tours, informational interviews

and/or job shadows. Each business tour, informational interview and/or job shadow shall include debriefing with the person after each opportunity. This service also includes introductory education on work incentives for individuals receiving publicly funded benefits (e.g. SSI, SSDI, Medicaid, Medicare, etc.), and includes introductory education on how Supported Employment services work (including VR services). Educational information is provided to the person and the legal guardian/conservator and/or most involved family member(s), if applicable, to ensure legal guardian/conservator and/or family support for the person's choice to pursue IIE or SE. The educational aspects of this service shall include addressing any concerns, hesitations or objections of the person and the legal guardian/conservator and/or most involved family member(s), if applicable. The Exploration service shall be completed no more than thirty (30) calendar days from the date of service initiation, unless extenuating circumstances warrant an extension. Exploration service is expected to involve, on average, forty (40) hours of service. 2. Discovery: This is a time-limited and targeted service for an individual who wishes to pursue IIE or SE but for whom more information is needed to determine the following prior to pursuing IIE or SE: o Strongest interests toward one or more specific aspects of the labor market; o Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through SE; o Conditions necessary for successful employment or SE. Discovery involves a comprehensive analysis of the person in relation to the three bullets above. Activities include observation of person in familiar places and activities, interviews with family, friends and others who know the person well, observation of the person in an unfamiliar place and activity, identification of the person's strong interests and existing strengths and skills that are transferable to IIE or SE, Discovery also involves identification of conditions for success based on experience shared by the person and others who know the person well, and observation of the person during the Discovery process. Discovery results in the production of a detailed written Profile, using a standard template prescribed by DIDD, which summarizes the process, learning and recommendations to inform identification of the person's IIE or SE goal(s) and strategies to be used in securing this employment or SE for the person. If Discovery is paid for through the Waiver, the person should be assisted to apply to VR for services to obtain IIE or SE. The Discovery Profile should be shared with VR staff to facilitate the expeditious development of an Individual Plan for Employment (IPE). Discovery shall be limited to no more than ninety (90) calendar days from the date of service initiation, Attachment 4 1915c Page 41 of 88 unless extenuating circumstances warrant an extension. This service is expected, on average, to involve fifty (50) hours of service. 3. Job Development: Job Development is support to obtain IIE or SE as defined above. The Job Development strategy should reflect best practices and whether customized employment is being sought. Job Development can also include SE Start Up which is support in establishing SE or a microenterprise, through implementation of a viable and comprehensive business plan. SE Start Up may include: a) aid to the individual in identifying potential business opportunities; b) assistance in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business; c) identification of the supports that are necessary in order for the individual to operate the business. The outcome of this service is expected to be the achievement of an IIE or SE outcome consistent with the individual's personal and

career goals. This service will be paid on an outcome basis once the person has completed two calendar weeks of IIE or SE Outcome payment amounts are tiered based upon the assessed level of need for the individual being served. 4. Job Coaching (JC): JC includes identifying, through job analysis, and providing services and supports that assist the individual in maintaining IIE or SE as defined above. JC includes supports provided to the individual and his/her supervisor and/or co-workers. Supports during each phase of employment must be guided by a JC Fading Plan which incorporates an appropriate mix of best practices for the individual to achieve fading goals as identified in the Plan (e.g. systematic instruction utilizing task analysis to teach the individual to independently complete as much of his/her job duties as possible; high or low tech assistive technology; and effective engagement of natural supports including co-workers and supervisor(s) as needed). If progress on fading ceases at some point, adaptations to job duties, negotiated with the supervisor/employer, may be utilized to allow fading to continue if no reduction in hours or hourly pay results. If an individual's support needs are one hour per week or less, JC through monthly Stabilization and Monitoring (SM) will be authorized. This requires a minimum of one monthly face-to-face contact with the supported employee, one monthly contact with the employer and ability of the provider to respond as needed to prevent job loss and where necessary, pursue a change in service authorization as needed to address longer term challenges to avoiding job loss. Attachment 4 1915c Page 42 of 88 JC can also include supports for persons participating in individualized, integrated SE, which includes identification and provision of services and supports that assist the individual in maintaining SE. Supports must enable the individual to successfully operate the business (with assistance from other sources of professional services or suppliers of goods necessary for the type of business). JC supports should never supplant the individual's role or responsibility in all aspects of the business. Supports during each phase of SE must be guided by a JC Fading Plan which incorporates an appropriate mix of best practices for the individual to achieve fading goals as identified in the Plan. (e.g. systematic instruction utilizing task analysis to teach the individual to independently complete as much of his/her roles and responsibilities as possible; high or low tech assistive technology; and effective engagement of any business partners and/or associates and/or suppliers of goods or services. If progress on fading ceases at some point, business plan adaptations may be utilized to allow fading to continue, if no reduction in paid hours or net hourly pay results. If an individual's support needs are one hour per week or less, JC through monthly SM will be authorized as defined and stated above. This requires a minimum of one monthly face-to-face contact with the supported employee and ability of the provider to respond as needed to prevent loss of SE and where necessary, pursue a change in service authorization as needed to address longer term challenges to avoiding loss of SE. The amount of time authorized for either type of JC is a percentage of the individual's hours engaged in employment or SE, based on need. For the Exploration and Discovery Service, the provider shall document each date of service, the activities performed that day, and the duration of each activity. Each service culminates in a written report summarizing the process and outcomes, using a standard template prescribed by DIDD. The written report is due no later than fourteen (14) calendar days after the last date of service is concluded. Exploration and Discovery are paid on an outcome basis, after the written report is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day,

and the duration of each activity. Specify applicable (if any) limits on the amount, frequency, or duration of this service: o The Waiver will not cover SE-IES services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If one or more of these services are authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). o SE-IES shall not be provided during the same time period that the person is receiving Personal Assistance, Respite, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego. Except for students who have graduated prior to May 2014, Attachment 4 1915c Page 43 of 88 employment and day services for school aged persons (i.e., under the age of 22) are limited to regular school break periods. o These services are only for individuals seeking or engaged in individualized integrated employment or self-employment. These services are not for group employment of any size or variation. o JC services do not include supports for volunteering or any form of unpaid internship, work experience or employment. o JC shall not be provided in excess of actual need and cannot be billed for more hours than the individual, engaged in employment or self-employment, has worked in a billing period. o These services do not include supporting paid employment or training in a sheltered workshop or similar facility-based setting. o These services do not include supporting paid employment or training in a business enterprise owned or operated by or affiliated with a provider of these services. However, those individuals who are currently employed by a provider to fulfill a contract authorized pursuant to TCA 71-4-701 et seq. may continue to receive supported employment services for paid employment or training until the contract expires or the person loses the employment for any other reason. At that point, any supported employment services the person receives must fully align with best practices in competitive integrated employment and the State's commitment to Employment First, and will no longer be used to support employment or training in a business enterprise owned or operated by or affiliated with a provider of these services. In limited circumstances where the person is working in an integrated employment arrangement, but the provider agency is serving as the EOR, providers will be permitted to bill for Employment Supports while EOR responsibilities are transitioned from the provider to the business/entity offering the integrated employment opportunity, in order to ensure that employment is not disrupted. o These services do not include payment for supervisory activities rendered as a normal part of the business setting and supports otherwise available to employees without disabilities filling the same or similar positions in the business. o Exploration: After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services) and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or selfemployment, or other services to obtain such employment. o Discovery: After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services

to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within 12. o Job Development (JD) including Self-Employment Start-Up: After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day Attachment 4 1915c Page 44 of 88 interval between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within 9 months. o Self-Employment Start-up: Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. o Non-residential habilitation services (SE-IES (except as noted below); Small Group ES; Community Participation Supports; IE&CI Wrap-Around Supports; FB Day Supports) and either the Residential SNAHomebound (HB) or the Non-Residential HB Service, when combined, may involve no more than 5,832 quarter hour units/year and no more than 240 quarter hour units in a fourteen day billing period. The Residential SNA-HB and the Non-Residential HB Service are paid on a per diem basis and each day shall be considered as 24 quarter hour units for the purposes of including this service in the annual and billing period limits. Under SE-IES, authorizations of Exploration, Discovery and JD are not included in these limits. o These services will not duplicate other services provided through the Waiver or the Medicaid State Plan. o Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: • Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; • Payments that are passed through to users of supported employment services; or • Payments for training that is not directly related to an individual's supported employment program. This service is available beginning Jan. 1, 2020. License (specify): N/A Certificate (specify): N/A Other Standard (specify): Please see below. The provider must meet the general requirements for all waiver service providers: 1. All providers shall be at least 18 years of age. 2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports. 3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance. Attachment 4 1915c Page 45 of 88 4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD). 5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry. 6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs. 7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements. 8. Individual staff delivering Supported Employment-Individual Employment Supports services shall also be required to meet the following qualifications: For Exploration and Job Coaching, the staff person shall have qualified as a Job Coach by either: (1) qualifying as a Job Developer as listed in 2. Below; or (2) successfully completing a competency-based training course

covering best practices in job coaching and consultation, pre-approved by DIDD and covering, at minimum, specific content prescribed in policy by DIDD. Example of acceptable course is: Training Resource Network, Inc. (TRN) Job Coaching and Consulting: Design, Training and Natural Support on-line web course. 2. For Discovery and Job Development, the staff person shall have successfully obtained one of the following to qualify as a Job Developer: a. Association of People Supporting Employment (APSE) Certified Employment Support Professional (CESP) Certificate received through passing an exam; OR b. ACRE Basic Employment Certificate – The Supported Employment Online Certificate Series earned through Virginia Commonwealth University; OR c. ACRE Basic Employment Certificate in Community Employment with Emphasis on Customized Employment offered by Griffin-Hammis Associates; OR d. ACRE Basic Employment Certificate – College of Employment Services (CES) Plus offered by University of Massachusetts Institute for Community Inclusion; OR e. ACRE National Certificate of Achievement in Employment Services earned through University of Tennessee; OR f. ACRE Professional Employment Certificate earned through completion of “Work Works” on-line course offered by University of Georgia Institute on Human Development and Disability.

Supported Employment-Small Group Employment Support

Service Definition (Scope):

This service provides employment services and training activities to support successful transition to individualized integrated employment or self-employment, or to supplement such employment and/or self-employment when it is only part-time. Service may involve small group career planning and exploration, small group Discovery classes/activities, other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment. Service may also include employment in integrated business, industry and community settings. Examples include mobile crews, small enclaves and other small groups participating in integrated employment that is specifically related to the identified interests, experiences and/or skills of each of the persons in the small group and that results in acquisition of knowledge, skills and experiences that facilitate transition to individualized integrated employment or self-employment, or that supplement such employment or selfemployment when it is only part-time. Maximum group size is four waiver participants. o Career planning and exploration activities, Discovery classes/activities, other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment or self-employment must be conducted in appropriate non-disability-specific settings (e.g. Job Centers, businesses, post-secondary education campuses, libraries, etc.) All settings must meet all HCBS setting standards and must not isolate participants from others who do not have disabilities. o In the enclave model, a small group of people with disabilities (no more than four people) is trained and supervised to work among employees who are not disabled at the host company's work site. Persons in the enclave may work as a team at a single work area or may work in multiple areas throughout the company. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others in the setting who do not have disabilities. The experience should allow opportunities for routine interactions with others without disabilities in the setting and involvement from supervisors and coworkers without disabilities (not paid to deliver this service) in the supervision and support of individuals receiving this service. o In the mobile work crew model, a small crew of workers (including no more than four persons with disabilities and ideally including workers without disabilities who are not paid support staff) work as a distinct unit and operate as a self-contained business that generates employment for their crew members by selling a service. The crew typically works at several locations within the community.

Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. The experience should allow opportunities for routine interactions with people without disabilities (including fellow crew members, customers, etc.) in the course of performing services. Paid work under Supported Employment—Small Group must be paid in accordance with all applicable federal and state labor laws, with the optimal expectation being wages that are at or above the state minimum wage. Further, the employment must provide an opportunity for participants, whether paid based on productivity or not, to earn an increased hourly wage over time as would be typical for other members of the general workforce. Supported Employment—Small Group does not include vocational or prevocational services, employment or training provided in facility-based work settings. Supported Employment—Small Group service settings cannot be provider-owned, leased or operated settings. The settings must be integrated in and support full access of participants to the greater community, including opportunities to learn about and seek individualized integrated employment or self-employment, engage in community life, and control their earned income. The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual's personal and career goals. Supported Employment—Small Group services shall be

provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment. Participants in this service shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the Individual Service Plan (ISP) must document that such opportunities are being provided through this service, to the individual, on an on-going basis. The ISP shall also document and address any barriers to the individual transitioning to individualized integrated employment or self-employment if the person is not already participating in individualized integrated employment or self-employment. Any individual using this service to supplement part-time individualized integrated employment or self-employment shall be offered assistance to increase hours in individualized integrated employment and/or self-employment as an alternative or partial alternative to continuing this service. Attachment 4 1915c Page 48 of 88 As a component part of this service, Supported Employment—Small Group service providers shall support individuals in identifying and pursuing any needed supports to take opportunities that will move them into individualized integrated employment or self-employment. An individual's person-centered support plan may include more than one non-residential habilitation service (Supported Employment-Individual Employment Supports; Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around Supports; Facility-Based Day Supports); however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time). Transportation during the provision of these services is included in the rates paid for these services. Transportation of a participant to and from these services is included in the rates paid for these services when such transportation is needed by a participant. The Supported Employment—Small Group provider shall be responsible for any personal assistance needs during the hours that Supported Employment-Small Group services are provided; however, the personal assistance services may not comprise the entirety of the Supported Employment—Small Group service. Specify applicable (if any) limits on the amount, frequency, or duration of this service: • Supported Employment—Small Group does not include vocational or prevocational services, habilitation services, employment or training provided in facility-based work settings. • Supported Employment—Small Group service settings cannot be provider-owned, leased or operated settings. Tennessee Department of Transportation rest areas, operated by a provider as part of State Use Program, where individuals employed are earning at least minimum wage, are excluded from this requirement. • Supported Employment—Small Group services exclude services available to an individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). • Supported Employment-Small Group Employment Supports shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego. Except for students who have graduated prior to May of 2014, Day Services for school aged persons (i.e., under the age of 22) are limited to regular school break periods. • Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: Attachment 4 1915c Page 49 of 88 • Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; • Payments that are passed through to users of supported employment services; • Payments for training that is not directly related to an individual's supported employment program. • Supported Employment—Small Group does not include supports for volunteering. • Non-residential habilitation services (Supported Employment-Individual Employment Supports (except as noted below); Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around Supports; Facility-Based Day Supports) and either the Residential Special Needs Adjustment-Homebound or the Non-Residential Homebound Support Service, when combined, may involve no more than 5,832 quarter hour units/year and no more than 240 quarter hour units in a fourteen day billing period. The Residential Special Needs Adjustment-Homebound and the Non-Residential Homebound Support Service are paid on a per diem basis and each day shall be considered as 24 quarter hour units for the purposes of including this service in the annual and billing period limits. Under Supported Employment-

Individual Employment Supports, authorizations of Exploration, Discovery and Job Development are not included in these limits. License (specify): N/A Certificate (specify): N/A Other Standard (specify): Please see below. The provider must meet the general requirements for all waiver service providers: 1. All providers shall be at least 18 years of age. 2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports. 3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance. 4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD). 5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry. 6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs. Attachment 4 1915c Page 50 of 88 7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

THERAPY/CLINICAL SERVICES

Behavior Services: Behavior Analyst and Behavior Specialist

Service Definition (Scope):

Behavior Services shall mean: a Services to assess and ameliorate person supported behavior that jeopardizes the health and safety of the person supported, that endangers others, or that prevents the person supported from being able to successfully participate in community activities; and

a. Development, monitoring, and revision of behavior intervention strategies, including development of a Behavior Support Plan and staff instructions for caregivers who are responsible for implementation of prevention and intervention strategies; and

b. The initial training of caregivers on the appropriate implementation of behavior intervention strategies, including the Behavior Support Plan (BSP) and staff instructions.

The BSP shall be developed through the person-centered planning process in collaboration with the person receiving the services, family members, the conservator if applicable and others selected by the person who will be supporting the person receiving the services, and responsible for implementing the BSP. Therapeutic goals and objectives shall be required for persons supported receiving Behavior Services. Behavior Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Speech, Language, and Hearing Services, unless there is documentation in the person's record of medical justification for the two services to be provided concurrently.

Behavior Services shall be provided by a Behavior Analyst face to face with the person supported except for:

(a) Completion of the Behavior Assessment Report;

(b) Person supported-specific training of staff, except in instances when the Behavior Analyst can demonstrate appropriate interventions in real time;

(c) Presentation of behavior information of the person supported at human rights committee meetings, behavior support committee meetings, and planning meetings related to the person supported. Reimbursement for presentation of behavior information related to the person supported at meetings shall be limited to a maximum of 5 hours per person supported per calendar year per provider.

Behavior assessments, behavior plan development, and presentations at meetings shall not be performed by Behavior Specialists. Behavior specialists are responsible for providing training, data collection and plan implementation but only behavior analysts can conduct a behavior assessment and

develop the behavior support plan. Reimbursement for behavior assessments shall be limited to a maximum of 8 hours per assessment (32 qtr hour units per calendar year) with a maximum of 2 assessments per calendar year.

Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first 30 calendar days following its approval for use shall be limited to a maximum of 6 hours (24 qtr hour units per calendar year). Reimbursement shall not be made for travel time to meetings and for telephone consultations, but may be made for consultations with treating the physician or psychiatrist during an office visit when the person supported is present.

Reimbursement for presentation of person supported behavior information at human rights committee meetings, behavior support committee meetings, and person supported planning meetings shall be limited to 5 hours per provider (20 qtr hour units per calendar year).

Behavior Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program, including psychological evaluations and psychiatric diagnostic interview examinations. Behavior Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

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

Reimbursement limits:
* 8 hours per assessment for completion of the behavior assessment; 2 assessments per year
* 6 hours per assessment for behavior plan development and staff training during the first 30 days following its approval; 2 assessments per calendar year
* 5 hours for presentations at meetings per calendar year

License (specify): N/A

Certificate (specify): N/A

Other Standard (specify):
A waiver service agency must ensure that employed Behavior Analysts and Behavior Specialist have

been approved by DIDD.

Provider Qualifications:

Behavior Analyst:

A Behavior Analyst must have a Master’s degree in behavior analysis, psychology, special education, or related field; a minimum of 12 credit hours of undergraduate or graduate level course work in behavior analysis; and a minimum of six (6) months full-time, supervised employment (or internship/practicum) in behavior analysis under the supervision of a behavior analyst. Supervision minimally consists of face-to- face meeting for the purpose of providing feedback and technical consultation at least once per week.

Behavior Specialist:

A Behavior Specialist must have a Bachelor's degree from an accredited college or university in one of the behavioral sciences or in an alternative discipline, and acceptable field work and experience equivalent to one (1) year of full-time behavioral therapy or behavioral modification.

Psychologist:

Psychologist - Must be licensed to practice in Tennessee (TDH Rules 1180-1 and 1180-2; TCA Title 63 Chapter 11).

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver’s license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Nursing

Service Definition (Scope):

Nursing Services shall mean skilled nursing tasks that must be performed by a registered or licensed nurse pursuant to Tennessee's Nurse Practice Act and that are directly provided to the person supported in accordance with a person-centered ISP. Nursing Services shall be ordered by the physician, physician assistant, or nurse practitioner of the person supported, who shall document the medical necessity of the services and specify the nature and frequency of the skilled nursing tasks to be performed. Nursing Services shall be provided face to face with the person supported by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse. Nursing Services shall also include the provision of services to teach and train the person supported and their family or other paid or unpaid caregivers how to manage the treatment regimen, and the provision of evaluation and training, specific to an individual person supported, by a registered nurse, for purposes of delegation of non-complex health maintenance tasks to unlicensed direct support staff, as determined appropriate by the delegating nurse, and as permitted by State law and contingent upon the registered nurse's evaluation of each individual's condition and also upon the registered nurse's evaluation of the competency of each unlicensed direct support staff. Evaluation, teaching and training required for delegation is considered part of the established rate; it is not billed separately.

The nurse shall also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the person supported during the period that Nursing Services are authorized and provided, unless such assistance cannot be safely provided by the nurse while also attending to the skilled nursing needs of the person supported (which must be documented in writing and approved pursuant to protocol). However, the amount of Nursing Services authorized and provided shall depend only on the skilled nursing needs of the person supported. Additional Nursing Services shall not be authorized only for purposes of providing unskilled needs.

A single nurse may provide services to more than one individual receiving services in the same setting, provided each person's needs can be safely and appropriately met. When Nursing Services are provided as a shared service for 2 or more individuals residing in the

same home (regardless of funding source), the total number of units of shared Nursing Services shall be apportioned based on the total units of nursing services prescribed for each person supported, and the apportioned amount shall be specified in the ISP for each person supported, as applicable. Only one unit of service will be billed for each unit of service provided, regardless of the number of persons supported. Documentation of service delivery must be kept for each person supported and shall reflect the total number of shared units of service provided, and the specific nursing tasks performed for that individual.

Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

Nursing Services shall consist of 2 categories of services and reimbursement:
a. RN services: RN services shall mean skilled nursing services, as specified above, which are provided by a registered nurse. This includes those services which require the skills of a registered nurse and which are required by Tennessee's Nurse Practice Act to be performed by a registered nurse.

b. LPN services: LPN services shall mean skilled nursing services, as specified above, which are provided by a licensed practical nurse working under the supervision of a registered nurse and which are permitted by Tennessee's Nurse Practice Act to be performed by a licensed practical nurse working under the supervision of a registered nurse.

This service shall be provided in home and community settings, as specified in the ISP, excluding schools, inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). A person supported who is receiving Medical Residential Services shall not be eligible to receive Nursing Services. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently.

Nursing Services are not intended to replace either intermittent home health skilled nursing visits or private duty nursing services available through the Medicaid State Plan/TennCare program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare

Program services shall be exhausted prior to using the waiver service. Nursing Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nursing Services shall be limited to a maximum of 48 units (12 hours) per day per waiver participant.

License (specify):
Waiver service agency - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed nurses are licensed to practice in the state of Tennessee (TDH 1370-1 Rules 1000-1 & 1000-2)

Other Standard (specify):
An LPN must work under the supervision of a licensed RN.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Nutrition

Service Definition (Scope):

Nutrition Services shall mean assessment of nutritional needs, nutritional counseling, and education of the person supported and of caregivers responsible for food purchase, food preparation, or assisting the person supported to eat. Nutrition Services must be provided in accordance with therapeutic goals and objectives specified in an ISP that is specific for the individual receiving services and developed by a dietitian or nutritionist. A dietitian or nutritionist who provides Nutrition Services must provide services within the scope of licensure and must be licensed as required by the State of Tennessee. Nutrition Services are intended to promote healthy eating practices and to enable the person supported and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner. Nutrition Services must be provided face to face with the person supported except for training caregivers responsible for food purchase or food preparation on the specific needs of the person supported, or assisting the person supported to eat and except for that portion of the assessment involving development of the ISP. To the greatest extent possible, it is expected that the person supported is engaged in these activities as learning opportunities.

Nutrition Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Speech, Language, and Hearing Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently.

The unit of reimbursement for a Nutrition Services assessment with plan development shall be per day. The unit of reimbursement for other Nutrition Services shall be per day. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one assessment visit per waiver participant (person supported) per waiver program year (calendar year). Nutrition Services other than the assessment (e.g., person supported-specific training of caregivers; monitoring dietary compliance and food preparation) shall be
limited to a maximum of one visit per day. Nutrition Services (including Nutrition Services assessments and other non-assessment services) shall be limited to a maximum of six (6) visits per waiver participant (person supported) per waiver program year (calendar year), of which no more than one (1) visit per waiver program year (calendar year) may be an assessment. A Nutrition Services assessment cannot be billed on the same day with other Nutrition Services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Nutrition Services unless provided by a licensed dietitian or nutritionist. Nutrition Services are not intended to replace services available through the Medicaid State Plan/TennCare program.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nutrition Services shall be limited to a maximum of six (6) visits per waiver participant per waiver program year (i.e. calendar year), of which no more than one (1) visit per waiver program year (i.e. calendar year) may be a Nutrition Services assessment.

Nutrition Services other than the assessment (e.g., service recipient-specific training of caregivers; monitoring dietary compliance and food preparation) shall be further limited to a maximum of one visit per day.

License (specify):
Dietitian or Nutritionist - Must have a valid license to practice in Tennessee (TDH Rule 0470-1).

Other Standard (specify):
Please see below.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver’s license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Occupational Therapy

Service Definition (Scope):

Occupational Therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations involving performance of activities of daily living; and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Occupational Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist. Occupational Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted). Occupational Therapy shall be provided in accordance with a treatment plan developed by a licensed occupational therapist based on a comprehensive assessment of the needs of the person supported and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Occupational Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Occupational Therapy services shall require documentation of reassessment of the condition of the person supported and continuing progress of the person supported toward meeting the goals and objectives.

Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Hearing, and Language Services; Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the person supported has a record of medical justification for the two services to be provided concurrently. Occupational Therapy is not intended to replace services that would normally be provided by direct care staff. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in

the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Occupational Therapy shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

The unit of reimbursement for an Occupational Therapy assessment with plan development shall be per day. The unit of reimbursement for other Occupational Therapy services shall be per 15 minutes.
Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Occupational Therapy services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Occupational Therapy unless provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

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

Reimbursement limits:
* 1 assessment with plan development per month;
* 3 assessments per year per provider; and
* 1.5 hours per day for services other than assessments.

License (specify):
Waiver service agency - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed therapists are licensed to practice in the state of Tennessee (TDH Rule 1150-2).

Other Standard (specify):
Occupational therapy assistants must work under the supervision of a licensed occupational therapist.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid drivers license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Orientation and Mobility

Service Definition (Scope):

Orientation and Mobility Services for Impaired Vision shall mean services:
(1) to assess the orientation and mobility of a person supported to determine functional limitations resulting from severe visual impairment and (2) to provide orientation and mobility training to enable a person supported with functional limitations resulting from severe visual impairment to move with greater independence and safety in the home and community environment. Orientation and Mobility Services for Impaired Vision shall be based on a formal assessment of the person supported and may include concept development (i.e. body image); motor development (i.e., motor skills needed for balance, posture and gait); sensory development (i.e. functioning of the various sensory systems); residual vision stimulation and training; techniques for travel (indoors and outdoors) including human guide technique, trailing, cane techniques, following directions, search techniques, utilizing landmarks, route planning, techniques for crossing streets, and use of public transportation; and instructional use of Low Vision devices. Orientation and Mobility Services for Impaired Vision shall be provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). Orientation and Mobility Services for Impaired Vision shall be provided face to face with the person supported except for training of caregivers responsible for assisting in the mobility of the person supported and except for that portion of the assessment involving development of the plan of care. Therapeutic goals and objectives shall be required for persons supported receiving Orientation and Mobility Services for Impaired Vision. Continuing approval of Orientation and Mobility Services for Impaired Vision shall require documentation of reassessment of the condition and continuing progress of the person supported toward meeting the goals and objectives.

Orientation and Mobility Services for Impaired Vision shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Behavior Services, or Speech, Language, and Hearing Services, unless there is documentation in the record of medical justification of the person supported for the two services to be provided concurrently. Orientation and Mobility Services for Impaired Vision shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. The unit of reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with plan development

shall be per day. The unit of reimbursement for other Orientation and Mobility Services for Impaired Vision shall be per 15 minutes. Reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with development of the plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Orientation and Mobility Services for Impaired Vision assessments shall not be billed on the same day with other Orientation and Mobility Services for Impaired Vision services.

Orientation and Mobility Services for Impaired Vision services other than such assessments (e.g., person supported training; person supported-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of 52 hours of services per person supported per calendar year. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Orientation and Mobility Services for Impaired Vision unless provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

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

Reimbursement limits:
* 1 assessment with plan development per month;
* 3 assessments per year per enrollee per provider; and
* 52 hours of non-assessment services per calendar year.

License (specify):
Certified orientation and mobility specialist - must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals.

Other Standard (specify):
Please see below.
The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Physical Therapy

Service Definition (Scope):

Physical therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations related to ambulation and mobility; and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Physical Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist. Physical Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted). Physical Therapy shall be provided in accordance with a treatment plan developed by a licensed physical therapist based on a comprehensive assessment of the needs of the person supported and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Physical Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Physical Therapy services shall require documentation of reassessment of the condition of the person supported and continuing progress of the person supported toward meeting the goals and objectives.

Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language, and Hearing Services; Nutrition Services, Orientation and Mobility Services for Impaired Vision; or Behavior Services, unless there is documentation in the individual's record of medical justification for the two services to be provided concurrently. Physical Therapy is not intended to replace services that would normally be provided by direct care staff. Physical Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Physical Therapy shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

The unit of reimbursement for a Physical Therapy assessment with plan development shall be per day. The unit of reimbursement for other Physical Therapy services shall be per 15 minutes. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan

based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Physical Therapy services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Physical Therapy unless provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

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

Reimbursement limits:
* 1 assessment with plan development per month;
* 3 assessments per year per provider; and
* 1.5 hours per day for services other than assessments.

License (specify):
Waiver service agency – Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed therapists are licensed to practice in the state of Tennessee (TDH Rule 1150-2).

Other Standard (specify):
Physical therapy assistants must work under the supervision of a licensed physical therapist.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or

Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Speech, Language and Hearing Services

Service Definition (Scope):

Speech, Language, and Hearing Services shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure which are provided to assess and treat functional limitations involving speech, language, or chewing/swallowing and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Speech, Language, and Hearing Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed speech language pathologist or by a licensed audiologist. Speech, Language, and Hearing Services must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the person supported except for that portion of the assessment involving development of the therapy plan of care. Speech, Language, and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language, and Hearing assessments (i.e., assess and treat orders are not accepted). Speech, Language, and Hearing Services shall be provided in accordance with a treatment plan developed by a licensed speech language pathologist or a licensed audiologist based on a comprehensive assessment of the needs of the person supported and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Speech, Language, and Hearing Services to prevent or minimize deterioration involving a chronic condition which would result in further loss of function.

Continuing approval of Speech, Language, and Hearing Services shall require documentation of reassessment of the person's condition and continuing progress of the person supported toward meeting the goals and objectives. Speech, Language, and Hearing Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the person's record of medical justification for the two services to be provided concurrently. Speech, Language, and Hearing Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Speech, Language, and Hearing Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

The unit of reimbursement for a Speech, Language, and Hearing Services assessment with plan development shall be per day. The unit of reimbursement for other Speech, Language, and Hearing Services shall be per 15 minutes. Reimbursement for a Speech, Language, and Hearing Services

assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per calendar year per person supported per provider. Speech, Language, and Hearing Services other than such assessments (e.g., person supported-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per person supported per day. Speech, Language, and Hearing Services assessments shall not be billed on the same day with other Speech, Language, and Hearing Services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Speech, Language, and Hearing Services unless provided by a licensed speech language pathologist or by a licensed audiologist.

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

Reimbursement limits:
* 1 assessment with plan development per month;
* 3 assessments per year per provider; and
* 1.5 hours per day for services other than assessments.

License (specify):
Waiver service agency - Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed therapists are licensed to practice in the state of Tennessee (TDH Rule 1150-2).

Other Standard (specify):
Please see below.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or

Medicaid programs.

7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Speech, Language and Hearing Services Assistive Technology

Service Definition (Scope):

Speech, Language and Hearing Assistive Technology does not have a separate service definition but does utilize a separate billing code. Being approved for this service allows an audiologist to bill for services at the same time as a speech language pathologist, using Speech, Language and Hearing Services simultaneously with Speech, Language and Hearing Assistive Technology

ANCILLARY SERVICES:

Environmental Accessibility Modifications

Service Definition (Scope):

Environmental Accessibility Modifications shall only mean the following modifications to the place of residence of the person supported: a. Physical modifications to the interior of a place of residence to increase the mobility and accessibility within the residence of the person supported; b. Physical modifications to an existing exterior doorway of place of residence to increase the mobility and accessibility for entrance into and exit from the residence of the person supported; c. A wheelchair ramp and modifications directly related to, and specifically required for, the construction or installation of the ramp; or as an alternative to a wheelchair ramp, a platform lift (to lift wheelchairs) and modifications directly related to, and specifically required for, the installation of a platform lift for one entrance into the residence; d. Hand rails for exterior stairs or steps to increase the mobility and accessibility of the person supported for entrance into and exit from the residence; or e. Replacement of glass window panes with a shatterproof or break-resistant material when medically necessary based on a history of destructive behavior by the person supported. The following are specifically excluded from coverage: a. Any adaptation or modification of the home which is of general utility and is not of direct medical or remedial benefit to the person supported; b. Any adaptation or modification which is considered to be general maintenance of the residence; c. Any physical modification to the exterior of the place of residence or lot of the person supported (e.g., driveways, sidewalks, fences, decks, patios, porches) that is not explicitly listed above as being covered; d. Any physical modification to garage doors for entry of vehicles; e. Any item that would be covered by the Medicaid State Plan/TennCare Program; f. Construction of an additional room or modification of an existing room which increases the total square footage of the residence; g. Construction of a new room within existing floor space (e.g., construction of an additional bathroom), including construction of new interior walls to subdivide existing rooms; h. A second or additional wheelchair ramp when there is a functional wheelchair ramp for one entrance into the residence of the person supported; i. A wheelchair ramp when there is a functional platform lift (to lift wheelchairs) for one entrance into the residence of the person supported; or a platform lift for entrance into the residence when there is a functional wheelchair ramp for one entrance into the residence; j. Platform lifts for use inside the place of residence of the person supported; k. Stairway lifts, stair glides, or elevators or the installation, repair, or replacement of stairway lifts, stair glides, or elevators; l. Repair or replacement of roofing or siding; m. Installation, repair, replacement, or painting of ceiling, walls, or floors or installation, repair, or replacement of carpet or other flooring except: (1) When the need for such is directly related to and necessitated by another approved environmental accessibility modification (e.g., flooring or carpet repair when a doorway is widened); and (2) When the cost of such is included in the cost of the other approved environmental accessibility modification; n. Rugs and floor mats; o. Furniture, lamps, beds, mattresses, bedding, and over bed tables; p. Water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers; q. Air conditioning or heating systems or units or the installation, repair, or replacement of air conditioning or heating systems or units; r. Electrical generators; emergency electrical backup systems; batteries, or battery chargers; s. Installation, repair, or replacement of electrical units or systems, except for the installation or replacement of electrical outlets which will be used for medical equipment; t. Lights or lighting systems or the installation, repair, or replacement of lights or lighting systems; except for the installation or replacement of lights when the need for such is directly related to and necessary in order to complete another approved environmental accessibility modification; u. Construction of additional exterior doorways or windows; v. Any item that meets the waiver service definition of Specialized Medical Equipment, Supplies, and Assistive Technology; w. Sprinklers and sprinkler systems; and x. Costs for removing an Environmental Accessibility Modification in order to convert or otherwise restore the place of residence to its pre-existing condition (i.e., the condition before the modification was made). Environmental Accessibility Modifications shall be recommended by a qualified health care professional (e.g.,physician, occupational therapist, physical therapist). To facilitate community transition of a Medicaid eligible person residing in an

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or other institutional setting who has been determined to qualify for HCBS waiver services upon discharge, Environmental Accessibility Modifications may be made to the place of residence of the persons supported during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. In such cases, the Environmental Accessibility Modification will not be considered complete until the date the person leaves the ICF/IID or other institutional setting and is enrolled in the waiver, and such date shall be the date of service for billing purposes. Environmental Accessibility Modifications shall be available only for newly enrolled waiver participants, including (but not limited to) persons transitioning to the community from an institutional setting, and existing waiver participants who have recently experienced a significant loss of mobility function. Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per person supported per three (3) consecutive waiver program years (calendar years). Reimbursement shall be subject to approval of an itemized competitive bid as required in accordance with the Department's policy on submission of bids. If the requirement for an itemized competitive bid is applicable, documentation of an approved bid must be submitted with the request for an Environmental Accessibility Modification, or the request will be denied. If the person supported does not own the place of residence, there must be written approval from the landlord for the Environmental Accessibility Modification to be approved. Such written approval must acknowledge that the person supported will not be responsible for the costs of removing an Environmental Accessibility Modification in order to convert or otherwise restore the place of residence to its pre-existing condition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per service recipient per three (3) consecutive waiver program years (i.e. calendar years).

Provider Specifications:

Provider Category	Provider Type Title
Agency	**Durable medical equipment supplier**
Agency	**Building supplier**
Agency	**Other retail business**
Individual	**Local contractor**
Individual	**Individual carpenter or craftsman (including a family member**

Durable medical equipment supplier

Provider Qualifications

License *(specify):*

Durable medical equipment supplier - Must be licensed in accordance with the requirements of the county or city where the service will be provided.

Building supplier - Must be licensed in accordance with the requirements of the county or city where the service will be provided.

Other retail business - Must be licensed in accordance with the requirements of the county or city where the service will be provided.

Local contractor - Must be licensed in accordance with the requirements of the county or city where the service will be provided.

Individual carpenter or craftsman - Must be licensed in accordance with the requirements of the county or city where the service will be provided.

Personal Emergency Response System

Service Definition (Scope):

A Personal Emergency Response System shall mean a stationary or portable electronic device used in the place of residence of the person supported which enables the person supported to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively. A Personal Emergency Response System shall consist of installation and testing of the Personal Emergency Response System as well as monthly monitoring performed by a response center.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Monitoring is limited to 1 unit/month (12 units/calendar year) maximum.

License (specify):
Must have a valid business license in Tennessee.

Other Standard (specify):
All devices must meet Federal Communications Commission, Underwriters Laboratory, or other equivalent standards and must be monitored by trained professionals.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

ENABLING TECHNOLOGY SERVICES

Enabling Technology

Service Definition (Scope):

Enabling Technology is equipment and/or methodologies that, alone or in combination with associated technologies, provides the means to support the individual's increased independence in their homes, communities, and workplaces. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform daily tasks that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation. Enabling Technology includes remote support technology systems in which remote support staff and/or coaches and/or natural supports can interact, coordinate supports, or actively respond to needs in person when needed. Remote support systems are real time support systems which often include two-way communication. Enabling technology is an available support option for all aspects and places of participants' lives.

• These systems use wireless technology, and/or phone lines, to link an individual's home to a person off-site to provide up to 24/7 support.

• These systems include the use of remote sensor technology to send "real time" data remote staff or family who are immediately available to assess the situation and provide assistance according to a Person-Centered Support Plan (PCSP).

Examples of enabling technologies typically used in peoples' homes include: • Motion sensors • Smoke and carbon monoxide alarms • Bed and/or chair sensors • Live or on demand audio and/or video technologies • Pressure sensors • Stove guards • Live web-based remote supports • Automated medication dispenser systems • Mobile software applications using digital pictures, audio and video to guide, teach, or remind • GPS guidance devices • Wearable and virtual technologies • Software to operate devices for environmental control or to communicate with other smart devices, paid or natural supports at home, at work, or any other place of personal import.

EMPLOYMENT & DAY SUPPORTS Mobile Technologies to teach safe travel skills and guide people during community travel to work or other places important in their lives, by walking or using public transportation. Enabling technology options include: • Mobile software applications using digital pictures, audio and video to guide, teach, or remind • GPS guidance devices • Wearable and virtual technologies • Software to support communication with people along participants' routes or destinations.

PRE-EMPLOYMENT: EXPLORATION Digital Career Exploration Self-directed or guided exploration of jobs and job tasks via a computer environment or a smart device's software application using digital pictures, audio and video to enable participants and job developers to identify jobs that match the individual's job interests. Digital tools for interest/skill exploration, member background information, scenario activities to identify skill set, learning styles, support needs. Virtual Reality Jobseekers can experience first-hand the pros and cons of various occupations by seeing, hearing and feeling what they are actually like.

PRE-EMPLOYMENT: DISCOVERY/JOB DEVELOPMENT Online tools for job hunting such as job boards; job interview tasks & tips, conditions for success, job/skill evaluations, scenario activities.

REMOTE COACHING Job Coaching includes supports provided to the person and their supervisor or co-workers, either remotely (via technology) or face-to-face. A device that otherwise meets the requirement for two-way communication.

Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Mobile technologies, video modeling, task prompting software applications, GPS-based applications; wearable technologies; virtual, augmented, mixed reality systems.

FADING A mobile technology that offers long-term support on the job, in lieu of paid support, that may encompass job tasks, social behavior, or communication. The use of enabling and/ or mobile technologies to support fading may

cover a wide array of person-centered needs that include attendance, punctuality, self-managing breaks, interpersonal skills, appearance, communication, sequencing job tasks, etc. The cost of connectivity by telephone and internet is not included with the Enabling Technology service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The service limit for Enabling Technology encompasses both Specialized Medical Equipment, Supplies, and Assistive Technology as well as Enabling Technology, i.e., a $10,000 limit per 2 waiver years across both services.

Specialized Medical Equipment Supplies and Assistive Technology

Service Definition (Scope):

Specialized Medical Equipment and Supplies and Assistive Technology shall only mean the following: a. An assistive device or adaptive aid or control designed for individuals with special functional needs which:
(1) Increases the ability to perform activities of daily living (e.g., adaptive eating utensils and dishware; an adaptive toothbrush); or
(2) Increases the ability to communicate with others (e.g., a hearing aid; an augmentative alternative communication device or system; an adaptive phone for individual with visual or hearing impairments); or
(3) Increases the ability to perceive or control the environment within the home (e.g., a smoke alarm with a vibrating pad or flashing light); and
a. A gait trainer; and
b. A sidelyer or similar positioning device; positioning wedges or rolls or similar positioning items; and
c. Supplies necessary for the proper functioning of specialized medical equipment or assistive technology covered within the scope of this waiver definition; and
d. Repair of specialized medical equipment or assistive technology devices covered within the scope of this waiver definition when the repair is not covered by warranty and when it is substantially less expensive to repair the equipment or device than replace it. Specialized Medical Equipment, Supplies, and Assistive technology shall be medically necessary and shall be recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist).
The following items are excluded from coverage:
a. Items not of direct medical or remedial benefit to the person supported;
b. Items covered by the Medicaid State Plan/TennCare Program;
c. Hearing aids and augmentative alternative communication systems for children under age 21 years;
d. Eyeglasses, frames, and lenses;
e. Elevators, stairway lifts, stair glides, platform lifts, stair-climbing devices, electric powered recliners, elevating seats, and lift chairs;
f. Sensory processing/sensory integration equipment or other items used in sensory integration therapy (e.g., ankle weights, weighted vests or blankets, sensory/therapy balls, swings, vibrators, floor mats, balance boards, brushes, trampolines);
g. Carpets, rugs, flooring, floor pads and mats; curtains, drapes, and window treatments; furniture, lamps, and lighting;
h. Beds, mattresses, bedding, and overbed tables;
i. Air conditioning systems or units, heating systems or units; water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;
j. Electrical generators, electrical service, or emergency electrical backup systems;
k. Adaptive devices for use with items specifically excluded by this waiver definition;
l. Recreational or exercise equipment and adaptive devices for such; adaptive tricycles;
m. Toys, toy equipment, and adaptive devices for toys (e.g., flash switches);
n. Radios, televisions, or related electronic audiovisual equipment (e.g., DVD players); telephone, television, or internet service; and equipment or items for education, training, or entertainment purposes;
o. Personal computers; printers, monitors, scanners, and other computer-related hardware and software (excluding equipment designed specifically and primarily to be used as an augmentative alternative communication systems for adults);
p. Orthotics;
q. Stethoscopes or blood pressure cuffs;

r. Clothing;
s. Diapers and other incontinence supplies;
t. Food, food supplements, food substitutes (including formulas), and thickening agents;
u. Prescription and over-the-counter medications; vitamins, minerals, and nutritional supplements;
v. Swimming pools, hot tubs, whirlpools and whirlpool equipment, and health club memberships;
w. Lifting and tracking systems for transfer of persons supported;
x. Supplies other than those supplies specifically required for the proper functioning of specialized medical equipment or assistive technology devices that are covered within the scope of this definition;
y. Duplicate items of specialized medical equipment or assistive technology, excluding adaptive eating utensils and dishware, to provide the person supported with a backup or spare;
z. Repair of equipment covered by warranty;
aa. Physical modification of the interior or exterior of a place of residence; and
bb. Physical modification of a motor vehicle or motor vehicle parts and services, including adaptive devices to facilitate driving.

Specialized Medical Equipment, Supplies and Assistive Technology is not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Reimbursement shall be subject to approval of an itemized competitive bid as required in accordance with the Department's policy on submission of bids. If the requirement for an itemized competitive bid is applicable, documentation of an approved bid must be submitted with the request for the Specialized Medical Equipment, Supplies, and Assistive Technology or the request will be denied. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per person supported per 2 waiver program years (calendar years). The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item. All medically necessary services that are included within the categories of mandatory and optional services listed in section 1905(a) shall be covered under the federal EPSDT program for children under age 21. Items and services beyond the scope of EPSDT but included in the approved definition for Specialized Medical Equipment and Supplies and Assistive Technology may be covered for children under age 21 enrolled in the waiver based on medical necessity.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per service recipient per 2 waiver program years (i.e. calendar years).

Provider Specifications:

Provider Category	**Provider Type Title**
Agency	**Other retail or wholesale business entity**
Agency	**Durable medical equipment supplier**

Other retail or wholesale business entity - With the exception of a sole source manufacturer licensed in another state, must have a wholesale or retail business license in Tennessee (to sell equipment, supplies, etc.)

Durable medical equipment supplier - With the exception of a sole source manufacturer licensed in another state, must have a wholesale or retail business license in Tennessee (to sell equipment, supplies, etc.)

Personal Assistance

Service Definition (Scope):

Personal Assistance shall mean a type of service, selected by the person supported, offering individualized services and supports that enable the person to live in the community in a setting of their choice and which supports each person's independence, rights, and full inclusion in the community; and ensures each resident's choice and rights.

Personal Assistance services shall be delivered in a manner that comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person- centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual.

Supports may include of direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, meal preparation excluding cost of food, toileting and incontinence care, assistance with transfer and mobility), household chores essential to the health and safety of the person supported (e.g., washing dishes; personal laundry; general housecleaning in areas of the residence used by the person supported); budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), supervising and accompanying the person supported to medical appointments if
needed, and on personal errands such as grocery shopping, picking up prescriptions, paying bills; and trips to the post office.

Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Personal Assistance may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law.

Personal Assistance is a service that is provided for the direct benefit of the person supported. It is not a service that provides direct assistance to other members of the household (e.g., preparation of meals for the family, family laundry) who are not persons supported through the waiver.

Personal Assistance staff shall not provide any personal assistance services to family members of the person supported, unless such family members are also supported through the waiver residing in the same home (e.g., when 2 siblings in the home are both waiver participants).

A single staff person may provide Personal Assistance services to more than one individual residing in the same home at the same time, provided each person's needs can be safely and appropriately met. When Personal Assistance is provided as a shared service for 2 or more family members residing in the same home (regardless of funding source), the total number of units of shared Personal Assistance shall be apportioned based on an assessment of individual need and the apportioned amount included in the ISP for each waiver participant, as applicable. Only one unit of service will be billed for each unit of service provided, regardless of the number of persons supported.

Documentation of service delivery must be kept for each person supported and shall reflect the total number of shared units of service provided, and the tasks performed/assistance provided for that individual.
Personal Assistance is often delivered in the place of residence of the person supported; however, it may be provided outside the person supported home in community-based settings where the Personal Assistance provider accompanies the person supported to perform tasks and functions in accordance with the approved service definition and as specified in the person-centered ISP.
Personal Assistance does not include routine provision of Personal Assistance services in an area outside the person's local community of residence. On an infrequent and exceptional basis and in accordance with the approved person-centered ISP, Personal Assistance services may be provided in an area outside the person's local community of residence.
Personal Assistance may be provided in the home or community; however, it shall not be provided in schools for school-age children, to replace personal assistance or similar services required to be covered by schools, to transport or otherwise take children to or from school, or to replace services available through the Medicaid State Plan/TennCare Program.
Personal Assistance services shall not be provided in the home of the Personal Assistant, except 1) when the person supported lives in the home with the Personal Assistant or 2) on an infrequent and exceptional basis when the person supported is attending a special event (e.g., a party) that is held in the home of the Personal Assistant. Services provided in the Personal Assistant's home must be specified and in accordance with the approved person-centered ISP.
Personal Assistance may be provided during the day or night, as specified in the person-centered ISP.
A person supported who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance.
Individuals receiving Personal Assistance services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.
Personal Assistant Services shall not be provided during the same time period that the person supported is receiving Day Services, Respite Services, services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego.
This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Personal Assistance shall not be provided in a licensed facility (e.g., a group home, boarding home, or assisted living home) when the facility's licensure category requires the provision of personal assistance or personal care services.
Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the person supported.
The Personal Assistant shall not be the spouse of a person supported and shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Personal Assistance provided by such individuals.
Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.
Family members are required to implement services as specified in the person-centered ISP.

Reimbursement to family members shall be limited to forty hours per week per family member. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program. The unit of reimbursement for Personal Assistance services shall be 15 minutes.
The Personal Assistance provider is not obligated to provide transportation for the person supported as part of the Personal Assistance service; however, a Personal Assistance provider who is also an Individual Transportation Services provider may bill for Individual Transportation Services for transport of the person supported into the community.
Personal Assistance may be provided out-of-state under the following circumstances:
a. Out-of-state services shall be subject to the same monthly limitation as Personal Assistance services provided in-state and in addition, are limited to a maximum of 14 days of service per person supported per waiver program year (calendar year), regardless of the number of hours of service provided each day.
b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.
d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal Assistance services shall be limited to a maximum of 860 units (215 hours) per waiver participant per month. Out of state Personal Assistance services are subject to the same monthly limitation, and in addition, are limited to a maximum of 14 days per waiver participant per waiver program year (i.e. calendar year).
Self-Determination requires the following:
Reimbursement to family members shall be limited to forty hours per week per family member for self- directed services as well as those delivered by contracted provider agencies.
CAC and Statewide waivers require the following:
Reimbursement to family members shall be limited to forty hours per week per family member.
License (specify):
Please see below.
Self-Determination requires the following:
Waiver service agency - Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Personal Assistance Service provider.
Statewide waiver requires the following:
Waiver service agency-Must be licensed by the Department of Intellectual and Developmental Disabilities as a Personal Assistance Service provider.

CAC Waiver requires the following:
Individual - Must be licensed by the Department of Intellectual and Developmental Disabilities as a Personal Assistance Service provider, if more than one individual is served.

Other Standard (specify):
Please see below.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Respite

Service Definition (Scope):

Respite shall mean services provided to a person supported when unpaid caregivers are absent or need relief from routine caregiving responsibilities. Respite may be provided in the person's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/IID, in a home operated by a licensed residential provider, in a licensed respite care facility, or in the home of an approved respite provider. The Respite provider may also accompany the person on short outings for exercise, recreation, shopping, or other purposes while providing respite care.
Reimbursement for Respite shall not include payment for Respite provided by the spouse of a person supported or family member or relative (whether by birth or marriage) who resides with the person supported in the home. The Respite provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Respite provided by such individuals. Reimbursement for Respite shall not include payment for Respite provided by any individual who has been appointed as the conservator for the person supported unless so permitted in the Order for Conservatorship. Family members who provide Respite must meet the same standards as providers
who are unrelated to the person supported, including implementing services as specified in the individual support plan (ISP).
When less than 8 hours of respite services is needed in a day, the unit of reimbursement shall be per 15 minutes. When 8 hours or more of respite services are needed in a day, the unit of reimbursement shall be per day. Level 1 per day reimbursement shall be for persons requiring at least 8 hours, but less than 16 hours of respite services in a day. Level 2 per day reimbursement shall be for persons requiring at least 16 and up to 24 hours of respite services in a day, but no awake overnight direct support staff. Level 3 per day reimbursement shall be for persons requiring 24 hour respite services, including awake overnight direct support staff.
Respite shall be limited to a maximum of 30 days per person supported per waiver program year (i.e. calendar year). Family members are required to implement services as specified in the ISP. Reimbursement to family members shall be limited to forty hours per week per family member for self- directed services as well as those delivered by contracted provider agencies. The person's Circle of Support shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.
A person receiving respite for a period less than 24 hours per day may also receive Supported Employment (Individual Employment Supports and Small Group), and Day Services (Community Participation Supports, Intermittent Employment and Community Participation Wraparound, Facility-Based Day Supports and Non-Residential Homebound Support Services) on the same day that respite is provided, provided that respite shall not be provided or reimbursed at the same time as any employment or day service. Reimbursement for respite is based on the actual time spent providing respite (unduplicated with any other service, including employment and day). Providers who receive the Level 3 per diem reimbursement rate for Respite shall be responsible for the cost of any Day Services needed while the person is receiving Respite services.
While Respite Services can be provided on the same date of employment and day services, Respite shall not be provided during the same time period that the person supported is receiving Personal Assistance Services, Day Services, Employment Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to a maximum of 30 days per person supported per calendar year.
License (specify):
Licensed Respite Care Facility: must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility if an ICF/IID or as an Intellectual Disability/Developmental Disability Respite Care Services Facility if not an ICF/IID.
Waiver service agency: Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility.
Licensed Residential Provider: Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility.
Medicaid-certified ICF/IID:
Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Institutional Habilitation Facility.
Approved Respite Provider:
Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Respite Care Services Facility if serving more than one individual.
Other Standard (specify):
Please see below.
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Behavior Respite

Service Definition (Scope):

Behavioral Respite Services shall mean short-term behavior-oriented services for a person supported who is experiencing a behavioral crisis that requires removal from the current residential setting in order to assist in resolving the behavioral crisis. Behavioral Respite Services providers shall also help to plan, coordinate, and prepare for the individual's transition back to his/her residential setting.

Behavioral Respite Services shall be provided in a setting staffed by individuals who have received training in the management of behavioral issues. Direct support staff must have received training in the prevention and management of crisis behavior. Behavioral Respite Services may be provided in a Medicaid-certified ICF/IID, in a licensed respite care facility, or in a home operated by a licensed residential provider. Behavioral Respite Services shall not be provided in a home where a person supported lives with family members unless such family members are also persons supported receiving Behavioral Respite Services. Family member shall be interpreted to mean the mother, father,grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

The Behavioral Respite Services provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the person supported is not at school, including behavioral supervision and intervention for aggressive or inappropriate behavior that jeopardizes the health and safety of the person supported or others. The Behavioral Respite Services provider shall oversee health care needs of the person supported. Behavioral Respite Services providers shall be responsible for the cost of any Day Services needed while the person supported is receiving Behavioral Respite Services.

Reimbursement for Behavioral Respite Services shall not include payment for Behavioral Respite Services provided by the spouse of a person supported. The Behavioral Respite Services provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Behavioral Respite Services provided by such individuals.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Behavioral Respite Services and shall be included in the reimbursement rate for such. A person supported who is receiving Behavioral Respite Services shall not be eligible to receive Personal Assistance, Respite, or Day Services (which would duplicate services that are the responsibility of the Behavioral Respite Services provider). Behavioral Respite Services shall be limited to a maximum of 60 days per person supported per waiver (i.e., calendar) year. Restraints shall not be used unless used in accordance with the Department's policy on use of restraints.

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

Behavioral Respite Services shall be limited to a maximum of 60 days per service recipient per waiver year (i.e. calendar year).

License (specify):

Licensed respite care facility - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Facility if an ICF/IID or as an Intellectual Disability/Developmental Disability Respite Care Services Facility if not an ICF/IID.

Medicaid-certified ICF/IID - Must be licensed by the Department of Intellectual and Developmental

Disabilities as an Intellectual Disability/Developmental Disability Institutional Habilitation Facility.
Licensed Residential Provider - Must be licensed by the Department of Intellectual and Developmental Disabilities as an Intellectual Disability/Developmental Disability Residential Habilitation Facility.
Certificate (specify): N/A
Other Standard (specify):
Staff must meet DIDD provider qualification and training requirements. Direct support staff must have received training in the prevention and management of crisis behavior.
The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Support Coordination Services

Service Definition (Scope):

Support Coordination shall mean the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities to develop personal relationships, participate in their community, increase control over their own lives, and develop the skills and abilities needed to achieve these goals, person supported as specified in person supported the individual's person-centered Individual Support Plan (ISP). Support Coordination shall be provided in a manner that comports fully with standards applicable to person- centered planning for services delivered under Section 1915(c) of the Social Security Act.

Specific tasks performed by the Support Coordination provider shall include, but are not limited to general education about the waiver program, including individual rights and responsibilities; providing necessary information and support to the individual to support his/her direction of the person-centered planning process to the maximum extent desired and possible; initial and ongoing assessment of the individual's strengths and needs; identification of what is important to the individual, including preferences for the delivery of services and supports; actual development, ongoing evaluation, and updates to the ISP as needed or upon request of the individual; coordination with the individual's health care providers and MCO(s), as applicable, to ensure timely access to and receipt of needed physical and behavioral health services; supporting the individual's informed choice regarding services and supports they receive, providers who offer such services, and the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS; specific documentation of any modifications to HCBS settings requirements based on the needs of the individual and in accordance with processes prescribed in federal and state regulation and protocol; and monitoring implementation of the ISP and initiating updates as needed and addressing concerns which may include reporting to management level staff within the provider agency; or reporting to DIDD when resolution is not achieved and the ISP is not being implemented. The ISC will provide the individual with information about self-advocacy groups and self- determination opportunities and assist in securing needed transportation supports for these opportunities when specified in the ISP or upon request of the individual.

Ongoing monitoring by the ISC is accomplished through a stratified approach, based on level of support need, as follows:

A person assessed to have level of need 1, 2, or 3 for purposes of reimbursement or not receiving any residential or day service reimbursed based on level of need requires a minimum of at least one monthly in-person or telephone contact and at least one bi-monthly (every other month) face-to-face contact; at least one visit per quarter shall be conducted in the person's home. A person assessed to have level of need 4, 5, or 6 for purposes of reimbursement requires a minimum of at least one monthly face-to-face contact across all environments and in the person's residence at least quarterly. Residential level of reimbursement is the overriding determinant of the contact frequency. Day services level of need will only determine visit frequency if the person receives no residential services. Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ISP for that person per service received across service settings. Generally, face-to-face visits should be coordinated with the person supported (and their family, as applicable) to occur in the person's residence. However, for persons not receiving residential services, if requested by the person (or their family, as applicable), visits can be

scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request or based on a significant change in needs or circumstances. Information is gathered using standardized processes and tools.

The Support Coordination provider shall initiate and oversee at least annual reassessment of the individual's level of care eligibility, and initial and at least annual assessment of the individual's experience to confirm that that the setting in which the individual is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

The Support Coordinator must have:

1. A bachelor's degree from an accredited college or university in a human services field; or
2. A Bachelor's degree from an accredited college or university in a non-related field and one year of relevant experience; or
3. Associate degree plus two (2) years of relevant experience; or
4. Four (4) years of relevant experience.

Relevant experience means experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.

Support coordinators who do not have a Bachelors medical degree in a human services field must be supervised by someone who does meet that qualification.

Support Coordinators must successfully complete required pre-service training courses as well as periodic in-service training and any other any re-training required to maintain approval to be a Support Coordinator.

The provider must meet the general requirements for all waiver service providers:

1. All providers shall be at least 18 years of age.
2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid drivers license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Individual Transportation (Orientation & Mobility Only)

Service Definition (Scope):

Individual Transportation Services shall mean non-emergency transport of a person supported to and from approved activities specified in the ISP. Whenever possible, immediate family members, friends who are involved in providing supports and community agencies who can provide this service without charge should be utilized.

The following transportation services are excluded from coverage:
a. Transportation to and from medical services covered by the Medicaid State Plan/TennCare Program; and
b. Transportation of school aged children to and from school; and
c. Transportation to and from supported or competitive employment; and
d. Transportation that is the responsibility of the provider of a residential service (e.g., Residential Habilitation, Medical Residential Services, Family Model Residential Support, or Supported Living) or that is the responsibility of the provider of Day Services or Behavioral Respite Services, since it would duplicate services that are the responsibility of such providers.

Individual Transportation Services shall not be provided by the spouse of a person supported and shall not be provided by the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption, and reimbursement shall not be provided for Individual Transportation Services provided by such individuals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to 31 days/month maximum.

License (specify):
Commercial transportation agency - Must have a business license. All drivers must have a valid driver's license of appropriate type (e.g., personal, commercial) for transport in Tennessee.

Waiver service agency - All drivers must have a valid driver's license of appropriate type (e.g., personal, commercial) for transport in Tennessee.

Individual - Must have a valid driver's license for transport in Tennessee.

Other Standard (specify):
The provider must maintain vehicle liability insurance.

The provider must meet the general requirements for all waiver service providers:
1. All providers shall be at least 18 years of age.

2. Staff who have direct contact with or direct responsibility for the service recipient shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
3. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driver's license and automobile liability insurance.
4. Staff who have direct contact with or direct responsibility for the service recipient shall pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities (DIDD).
5. Staff who have direct contact with or direct responsibility for the service recipient shall not be listed in the Tennessee Department of Health Abuse Registry or the Tennessee Sexual Offender Registry.
6. Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
7. All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.