Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter A, Introduction

§42.103. Definitions.
The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Actively involved--Significant, ongoing, and supportive involvement with an individual by a person, as determined by the individual's service planning team, based on the person's:

(A) interactions with the individual;

(B) availability to the individual for assistance or support when needed; and

(C) knowledge of, sensitivity to, and advocacy for the individual's needs, preferences, values, and beliefs.

(2) Activities of daily living (ADL)--Activities that are essential to daily self care, including bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transfer and ambulation, positioning, and assistance with self-administered medications.

(3) Adaptive aid--An item or service (including a medically necessary supply or device) that enables an individual to retain or increase the ability to:

(A) perform activities of daily living; or

(B) perceive, control, or communicate with the environment in which the individual lives.

(4) Adaptive behavior--The effectiveness with or degree to which an individual meets the standards of personal independence and social responsibility expected of the individual's age and cultural group as assessed by a standardized measure.

(5) Adaptive behavior level--The categorization of an individual's functioning level based on a standardized measure of adaptive behavior. Four levels are used ranging from mild limitations in adaptive skills (I) through profound limitations in adaptive skills (IV).

(6) Adaptive behavior screening assessment--A standardized assessment used to determine an individual's adaptive behavior level, and conducted using one of the following assessment instruments:

(A) American Association of Intellectual and Developmental Disabilities (AAIDD) Adaptive Behavior Scales (ABS);

(B) Inventory for Client and Agency Planning (ICAP);

(C) Scales of Independent Behavior--Revised (SIB-R); or

(D) Vineland Adaptive Behavior Scales, Second Edition (Vineland-II).

(7) Assisted living facility (ALF)--An entity required to be licensed under the Texas Health and Safety Code, (THSC), Chapter 247, Assisted Living Facilities.

() Behavioral emergency--A situation in which an individual is acting in an aggressive, destructive, violent, or self-injurious manner that poses a risk of death or serious bodily harm to the individual or others.

(8) Behavioral support--Formerly referred to as "behavior communication," a service that provides specialized interventions that assist an individual to increase adaptive behaviors to

replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life, with a particular emphasis on communication as it affects behavior.

(9) Business day--Any day except a Saturday, a Sunday, or a national or state holiday listed in Texas Government Code §662.003(a) or (b) ~~A day when DADS' administrative offices are open~~.

() Calendar day--Any day, including weekends and holidays.

(10) Case management--Services that assist an individual to gain access to needed waiver and other state plan services, as well as needed medical, social, education, and other services, regardless of the funding source for the services.

(11) Case manager--A service provider who is responsible for the overall coordination and monitoring of DBMD Program services provided to an individual.

(12) CDS option--Consumer directed services option. A service delivery option as defined in §41.103 of this title (relating to Definitions) ~~in which an individual or LAR employs and retains service providers and directs the delivery of program services~~.

(13) CDSA--FMSA. ~~Consumer directed service agency. An entity, as defined in §41.103 of this title, that provides financial management services to an individual participating in the CDS option.~~

(14) Chore services--Services needed to maintain a clean, sanitary, and safe environment in an individual's home.

(15) CMS--The Centers for Medicare and Medicaid Services.

~~(16) Competitive employment--Employment that pays an individual at or above the greater of:~~
~~(A) the applicable minimum wage; or~~
~~(B) the prevailing wage paid to individuals without disabilities performing the same or similar work.~~

() Contract--A written agreement between DADS and a program provider for the program provider to provide DBMD Program services.

(17) DADS--The ~~Texas~~ Department of Aging and Disability Services.

(18) DAHS (Day Activity and Health Services)--Services as defined in §98.2(17) of this title (relating to Definitions).

(19) DBMD Program--The Deaf Blind with Multiple Disabilities Waiver Program.

(20) DBMD Program specialist--Employee in DADS' state office who is the primary contact for the DBMD Program.

(21) Deafblindness--A chronic condition in which a person:

(A) has deafness, which is a hearing impairment severe enough that most speech cannot be understood with amplification; and

(B) has legal blindness, which results from a central visual acuity of 20/200 or less in the person's better eye, with correction, or a visual field of 20 degrees or less.

(22) Denial--A DADS' action that disallows:

(A) an individual's request for enrollment in the DBMD Program;

(B) a service requested on an IPC that was not authorized on the prior IPC; or

(C) a portion of the amount or level of a service requested on an IPC that was not authorized on the prior IPC.

(23) Dental treatment--A service that provides the following services, as described in Appendix C of the DBMD Program waiver application (found on the DBMD Program page of DADS website at www.dads.state.tx.us):

(A) therapeutic, orthodontic, routine preventive, and emergency treatment; and

(B) sedation.

(24) Developmental disability--As defined in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, Section 102(8), a severe, chronic disability of an individual five years of age or older that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the individual attains 22 years of age;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity:

(i) self-care;

(ii) receptive and expressive language;

(iii) learning;

(iv) mobility;

(v) self-direction;

(vi) capacity for independent living; and

(vii) economic self-sufficiency.

(25) DFPS--Department of Family and Protective Services.

(26) Dietary services--A therapy service that:

(A) assists an individual to meet basic or special therapeutic nutritional needs through the development of individual meal plans; and

(B) is provided by a person licensed in accordance with Texas Occupations Code, Chapter 701, Dieticians.

(27) Employment assistance--Assistance provided to an individual to help the individual locate paid employment in the community ~~A service that assists an individual to obtain competitive, integrated employment~~.

(28) FMS--Financial management services.~~--~~Services, as defined in §41.103 of this title provided to an individual who chooses to participate in the CDS option.

() FMSA--Financial management services agency. An entity, as defined in §41.103 of this title, that provides FMS to an individual participating in the CDS option.

(29) Functions as a person with deafblindness--Situation in which a person is determined:

(A) to have a progressive medical condition, manifested before 22 years of age, that will result in the person having deafblindness; or

(B) before attaining 22 years of age, to have limited hearing or vision due to protracted inadequate use of either or both of these senses.

(30) Habilitation--Services that assist an individual in acquiring, retaining, and improving socialization and adaptive skills related to activities of daily living to enable the individual to live successfully in the community and participate in home and community life, including day habilitation and residential habilitation.

(31) HCSSA (Home and community support services agency) --An entity required to be licensed under THSC, Chapter 142, Home and Community Support Services.

(32) HHSC--Texas Health and Human Services Commission.

(33) ICF/IID--A facility in which ICF/IID Program services are provided.

(34) ICF/IID Program--The Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Program that provides Medicaid-funded residential services to individuals with an intellectual disability or related conditions.

(35) ICF/MR--ICF/IID.

(36) ICF/MR Program--ICF/IID Program.

(37) ID/RC Assessment (Intellectual Disability/Related Condition Assessment)--An assessment conducted to determine if an individual meets the diagnostic eligibility criteria for the DBMD Program.

(38) Impairment to independent functioning--An adaptive behavior level of II, III, or IV.

(39) Individual--A person seeking to enroll or who is enrolled in the DBMD Program.

(40) Institutional services--Services provided in an ICF/IID or a nursing facility.

~~(41) Integrated employment - Employment at a work site at which the individual routinely interacts with people without disabilities other than the individual's work site supervisor or service providers.~~

(42) Intellectual disability--Significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period.

(43) Intervener--A service provider who serves as a facilitator to involve an individual in home and community services and activities, and who is classified as an "Intervener", "Intervener I", "Intervener II", or "Intervener III" in accordance with Texas Government Code, §531.0973.

(44) IPC--Individual Plan of Care. A ~~written~~ DADS form that documents the plan developed by an individual's service planning team using person-directed planning that describes the type, amount, and estimated cost of each DBMD Program service to be provided to an individual.

(45) IPP--Individual Program Plan. A written plan completed by an individual's case manager that describes goals and objectives for each DBMD Program service included on the individual's IPC.

(46) IPC period--The effective period of an IPC as follows:

(A) for an enrollment IPC, the period of time from the effective date of service approved by DADS until the first calendar day of the same month of the effective date of service in the following year; and

(B) for a renewal IPC, a 12-month period of time starting on the effective date of a renewal IPC.

(47) LAR--Legally authorized representative. A person authorized by law to act on behalf of an individual with regard to a matter described in this chapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(48) Licensed assisted living--A service provided in a residence licensed in accordance with Chapter 92 of this title (relating to Licensing Standards for Assisted Living Facilities) for four to six individuals.

(49) Licensed home health assisted living--A service provided by a program provider licensed in accordance with Chapter 97 of this title (relating to Licensing Standards for Home and Community Support Services Agencies) in a residence for no more than three individuals, at least one of whom owns or leases the residence.

(50) LVN--Licensed vocational nurse. ~~(LVN)--~~A person licensed to provide vocational nursing in accordance with Texas Occupations Code, Chapter 301, Nurses.

() Mechanical restraint--A mechanical device, material, or equipment used to control an individual's behavior by restricting the ability of the individual to freely move part or all of the individual's body. The term does not include a protective device.

(51) Medicaid--A program funded jointly by the states and the federal government that provides medical benefits to groups of low-income people, some who may have no medical insurance or inadequate medical insurance.

(52) Medicaid waiver program--A service delivery model authorized under §1915(c) of the Social Security Act in which certain Medicaid statutory provisions are waived by CMS.

(53) Mental retardation--Intellectual disability.

(54) Minor home modifications--Physical adaptation to an individual's residence necessary to address the individual's specific needs and enable the individual to function with greater independence or control the residence's environment.

(55) MR/RC Assessment (Mental Retardation/Related Condition Assessment)--ID/RC Assessment.

(56) Natural supports--Assistance to help sustain an individual's living in the community from persons, including family members and friends, that occurs naturally within the individual's environment.

(57) Nursing--Treatments and health care procedures provided by a RN ~~registered nurse~~ or LVN ~~licensed vocational nurse~~ that are:

(A) ordered by a physician; and

(B) provided in compliance with:

(i) Texas Occupations Code, Chapter 301, Nurses; and

(ii) rules at Texas Board of Nursing at Texas Administrative Code (TAC), Title 22, Part 11, Texas Board of Nursing.

(58) Occupational therapy--Services that:

(A) address physical, cognitive, psychosocial, sensory, and other aspects of performance to support an individual's engagement in everyday life activities that affect health, wellbeing, and quality of life; and

(B) are provided by a person licensed in accordance with Texas Occupations Code, Chapter 454, Occupational Therapists.

(59) Orientation and mobility--Service that assists an individual to acquire independent travel skills that enable the individual to negotiate safely and efficiently between locations at home, school, work, and in the community.

(60) Person-directed planning--A process that empowers the individual (and the LAR on the individual's behalf) to direct the development of a plan for supports and services that meet the individual's outcomes. The process:

(A) identifies existing supports and services necessary to achieve the individual's outcomes;

(B) identifies natural supports available to the individual and negotiates needed services and supports;

(C) occurs with the support of a group of people chosen by the individual (and the LAR on the individual's behalf); and

(D) accommodates the individual's style of interaction and preferences regarding time and setting.

(61) Personal funds--The funds that belong to an individual, including earned income, social security benefits, gifts, and inheritances.

(62) Personal leave day--A continuous 24-hour period, measured from midnight to midnight, when an individual who resides in a residence in which licensed assisted living or licensed home health assisted living is provided is absent from the residence for personal reasons.

() Physical restraint--Any manual method, except for physical guidance or prompting of brief duration that an individual does not resist, that restricts:

(A) the free movement or normal functioning of all or a part of the individual's body; or

(B) normal access by an individual to a portion of the individual's body.

(63) Physical therapy--Services that:

(A) prevent, identify, correct, or alleviate acute or prolonged movement dysfunction or pain of anatomic or physiologic origin; and

(B) are provided by a person licensed in accordance with Texas Occupations Code, Chapter 453, Physical Therapists.

(64) Physician--As defined in §97.2(85) [~~§97.2(73)~~] of this title (relating to Definitions), a person who is:

(A) licensed in Texas to practice medicine or osteopathy in accordance with Texas Occupations Code, Chapter 155;

(B) licensed in Arkansas, Louisiana, New Mexico, or Oklahoma to practice medicine, who is the treating physician of a client and orders home health or hospice services for the client, in accordance with the Texas Occupations Code, §151.056(b)(4); or

(C) a commissioned or contract physician or surgeon who serves in the United States uniformed services or Public Health Service if the person is not engaged in private practice, in accordance with the Texas Occupations Code, §151.052(a)(8).
[~~holds a doctor of medicine or doctor of osteopathy degree and is currently licensed and practicing medicine under the laws of the state of Texas, Oklahoma, New Mexico, Arkansas, or Louisiana.~~]

(65) Program provider--An entity that ~~delivers~~ provides DBMD Program services under a contract ~~provider agreement~~.

() Protective device-

(A) Except as provided in subparagraph (B) of this paragraph, an item or device, such as a safety vest, belt, body strap, bed rail, safety padding or adaptation to furniture, if:

(i) used:

(I) to protect an individual from injury; or

(II) for body positioning of the individual to ensure health and safety; and

(ii) not used as a mechanical restraint to modify or control behavior.

(B) A helmet is a protective device if used to address a medical condition, such as seizures.

() Psychoactive medication restraint--A medication used to control an individual's behavior or to restrict the individual's freedom of movement that is not a standard treatment for the individual's medical or psychological condition.

~~(66) Provider agreement--A written agreement between DADS and a program provider that obligates the program provider to provide DBMD Program services.~~

(67) Reduction--A DADS action taken as a result of a review of a revision or renewal IPC that decreases the amount or level of a service authorized by DADS on the prior IPC.

(68) Related condition--As defined in the Code of Federal Regulations (CFR), Title 42, §435.1010, a severe and chronic disability that:

(A) is attributed to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition, other than mental illness, found to be closely

related to an intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability, and requires treatment or services similar to those required for individuals with an intellectual disability;

(B) is manifested before the individual reaches 22 years of age;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitation in at least three of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and

(vi) capacity for independent living.

(69) Request date--The date an individual or LAR requests the individual's name be added to the DBMD Program interest list.

(70) Respite--Services provided on a short-term basis to an individual because of the absence or need for relief of an individual's unpaid caregiver.

() Restraint--Any of the following:

(A) Physical restraint.

(B) Mechanical restraint.

(C) Psychoactive medication restraint.

() Restrictive Intervention--An action or procedure that limits an individual's movement, access to other individuals, locations or activities, or restricts an individual's rights.

(71) RN-- ~~(~~Registered nurse. ~~)~~--A person licensed to provide professional nursing in accordance with Texas Occupations Code, Chapter 301, Nurses.

() Seclusion--The involuntary separation of an individual away from other individuals in an area that the individual is prevented from leaving.

(72) Service planning team--A team comprising persons convened and facilitated by a DBMD Program case manager for the purpose of developing, reviewing, and revising an individual's IPC. The team includes:

(A) the individual;

(B) if applicable, the individual's LAR or an actively involved person;

(C) other persons whose inclusion is requested by the individual, LAR, or actively involved person;

(D) the program director or a RN ~~registered nurse~~ designated by the program provider; and

(E) other persons selected by the program provider who are:

(i) professionally qualified by certification or licensure and have special training and experience in the diagnosis and habilitation of persons with the individual's related condition; or

(ii) directly involved in the delivery of services and supports to the individual.

(73) Service provider--A person who provides a ~~direct~~ DBMD Program service directly to an individual and who is an employee or contractor of:

(A) the program provider; or

(B) the individual or LAR, if the individual has chosen the CDS option.

(74) Significantly subaverage general intellectual functioning--Consistent with Texas Health and Safety Code, §591.003, measured intelligence on standardized general intelligence tests of two or more standard deviations (not including standard error of measurement adjustments) below the age-group mean for the tests used.

(75) Speech, language, audiology therapy--Services that:

(A) address the development and disorders of communication, including speech, voice, language, oral pharyngeal function, or cognitive processes; and

(B) are provided by a person licensed in accordance with Texas Occupations Code, Chapter 401, Speech-Language Pathologists and Audiologists.

(76) Specialized nursing--Nursing provided to an individual who has a tracheostomy or is dependent on a ventilator.

(77) SSA--Social Security Administration.

(78) SSI--Supplemental Security Income.

(79) Support consultation--A service, as defined in §41.103 of this title, that may be chosen by an individual who chooses to participate in the CDS option.

(80) Supported employment--Assistance provided, in order to sustain paid employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. ~~A service that assists an individual to sustain competitive, integrated employment.~~

(81) TAC--Texas Administrative Code.

(82) TAS--~~(~~Transition Assistance Services. ~~)~~ --Services provided to a Medicaid-eligible person receiving institutional services in Texas to assist with setting up a household when transitioning from institutional services into the DBMD Program.

(83) TMHP--Texas Medicaid & Healthcare Partnership. The Texas Medicaid program claims administrator.

(84) Transfer--The movement of an individual from a DBMD Program provider or a FMSA ~~CDSA~~ to a different DBMD Program provider or FMSA ~~CDSA~~.

(85) Trust fund account--An account at a financial institution that contains an individual's personal funds and is under the program provider's control.

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter A, Introduction
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.104. Description of Deaf Blind with Multiple Disabilities (DBMD) Waiver Program.

(a) The Deaf Blind with Multiple Disabilities (DBMD) Program is a Medicaid waiver program. It provides community-based services and supports to an eligible individual as an alternative to the ~~Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR)~~ ICF/IID Program.

(b) DADS operates the DBMD Program under the authority of the Texas Health and Human Services Commission (HHSC).

(c) DADS limits the enrollment in the DBMD Program to the number of individuals approved by Centers for Medicare and Medicaid Services (CMS) and funded by the State of Texas.

(d) The DBMD Program offers the following services approved by CMS:

(1) adaptive aids;
(2) assisted living:
(A) licensed assisted living; and
(B) licensed home health assisted living;
(3) behavioral support;
(4) case management;
(5) chore services;
(6) day habilitation;
(7) dental treatment;
(8) dietary services;
(9) employment assistance;
(10) FMS ~~financial management services~~, if the individual is participating in the ~~Consumer Directed Services (~~CDS~~)~~ option;
(11) intervener;
(12) minor home modifications;
(13) nursing;
(14) occupational therapy;
(15) orientation and mobility;
(16) physical therapy;
(17) residential habilitation;
(18) respite;
(19) speech, language, audiology therapy;
(20) support consultation, if the individual is participating in the CDS option;
(21) supported employment; and

(22) TAS ~~Transition Assistance Services (TAS)~~.

(e) A program provider with a contract enrollment date on or after September 1, 2009, must serve all counties within a DADS region.

(f) A program provider with a contract enrollment date before September 1, 2009, may continue to serve only the counties specified in its contract. If such a program provider chooses to provide services in additional counties, the program provider does not have to serve all the counties within the DADS region.

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter B, Eligibility, Enrollment, and Review
Division 1, Eligibility
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.201. Eligibility Criteria.
An individual is eligible for DBMD Program services if:

(1) the individual is financially eligible for Medicaid because the individual receives supplemental security income cash benefits or is determined by HHSC to be financially eligible for Medicaid;

(2) the individual is determined by DADS to meet the diagnostic eligibility criteria described in §9.239 of this title (relating to ICF/MR Level of Care VIII Criteria);

(3) the individual, as documented on ~~a MR/RC~~ an ID/RC Assessment form:

(A) has one or more diagnosed related conditions and, as a result:

(i) has deafblindness;

(ii) has been determined to have a progressive medical condition that will result in deafblindness; or

(iii) functions as a person with deafblindness; and

(B) has one or more additional disabilities that result in impairment to independent functioning;

(4) the individual's related conditions, as described in paragraph (3)(A) of this section, manifested before the individual became 22 years of age;

(5) the individual has an IPC with a cost for DBMD Program services at or below 200 percent of the estimated annualized per capita cost of providing services in an ICF/IID ~~ICF/MR~~ to an individual who meets the diagnostic eligibility criteria described in §9.239 of this title considering all other resources, including resources described in §40.1 of this title (relating to Use of General Revenue for Services Exceeding the Individual Cost Limit of a Waiver Program);

(6) the individual is not enrolled in a Medicaid waiver program other than the DBMD Program or another DADS ~~DADS'~~ operated program as described in the *DBMD Program Manual* other than Day Activity and Health Services (DAHS);

(7) the individual does not reside in:

(A) an ICF/IID ~~ICF/MR~~;

(B) a nursing facility licensed or subject to being licensed in accordance with

Texas Health and Safety Code, Chapter 242, Convalescent and Nursing Homes and related Institutions;

(C) an assisted living facility (ALF) unless it provides licensed assisted living in the DBMD Program;

(D) a residential child-care operation licensed or subject to being licensed by DFPS unless it is a foster family home or a foster group home;

(E) a facility licensed or subject to being licensed by the Department of State Health Services (DSHS);

(F) a residential facility operated by the Texas Youth Commission; or

(G) a jail or prison; ~~and~~

(8) at least one program provider is willing to provide DBMD Program services to the individual; and [.]

(9) the individual resides or moves to reside in a county served by a program provider.

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter B, Eligibility, Enrollment, and Review
Division 2, Enrollment Process

§42.212. Process for Enrollment of an Individual.

(a) A program provider, upon notification by DADS that an individual designated the program provider on a completed Documentation of Provider Choice form, must assign a case manager to the individual.

(b) The program provider must ensure that the assigned case manager contacts the individual or LAR within five business days after the program provider receives the DADS notification ~~to the program provider~~. During the initial contact, the case manager must:

(1) verify that the individual resides in a county for which the program provider has a contract ~~provider agreement~~;

(2) determine if the individual is currently enrolled in Medicaid;

(3) determine if the individual is currently enrolled in a Medicaid waiver program other than the DBMD Program, or another DADS-operated program described in the *DBMD Program Manual* other than DAHS; and

(4) arrange with the individual and LAR for an initial face-to-face, in-home visit to occur as soon as possible but no later than 30 calendar days after the program provider receives the DADS notification ~~to the program provider~~.

(c) During the initial face-to-face, in-home visit, the case manager must:

(1) explain to the individual or LAR:

(A) the DBMD Program services and supports;

(B) the application and enrollment process described in this chapter;

(C) the individual's rights and responsibilities, including the right to request a Medicaid Fair Hearing as described in §42.251 of this chapter (relating to Individual's Right to a Fair Hearing);

(D) the mandatory participation requirements as described in §42.252 of this chapter (relating to Mandatory Participation Requirements of an Individual);

(E) if the individual is enrolled in a Medicaid waiver program other than the DBMD Program or another DADS-operated program described in the *DBMD Program Manual* other than DAHS, that the individual or LAR must choose between the DBMD Program and the other program;

(F) the procedures for an individual or LAR to file a complaint regarding a DBMD Program provider;

(G) the CDS option as described in §42.217 of this chapter (relating to Consumer Directed Services (CDS) Option);

(H) if the individual is Medicaid-eligible and receiving institutional services, TAS as described in Chapter 62 of this title (relating to Contracting to Provide Transition Assistance Services);

(I) the voter registration process, if the individual is 18 years of age or older; and

(J) how to contact the program provider, the case manager, and the RN ~~registered nurse~~;

(K) that the individual or LAR may request the provision of residential habilitation, case management, nursing, out-of-home respite in a camp, adaptive aids, or intervener services while the individual is temporarily staying at a location outside the contracted service delivery area but within the state of Texas during a period of no more than 60 consecutive days; and

(L) orally and in writing, procedures for reporting an allegation of abuse, neglect, and exploitation.

(2) if possible:

(A) complete an adaptive behavior screening assessment ~~, if appropriate,~~ or ensure an appropriate professional completes the adaptive behavior screening assessment ~~is completed by an appropriate professional~~; and

(B) ensure a RN completes a nursing assessment utilizing the DADS DBMD Nursing Assessment form ~~is completed by a registered nurse as described in the *DBMD Program Manual*~~;

(3) complete the ID/RC Assessment form; and

(4) obtain the signature of the individual or LAR on:

(A) the Verification of Freedom of Choice form designating the individual's choice of DBMD Program services over enrollment in the ICF/IID Program; and

(B) DADS Release of Information Consent form or a similar form developed by the program provider.

(d) If one or both of the assessments described in subsection (c)(2) of this section is not completed during the initial face-to-face, in-home visit, the case manager must ensure that the

assessment is completed within 10 business days after the date of the initial face-to-face, in-home visit.

(e) If the individual is Medicaid eligible, is receiving institutional services, and anticipates needing TAS, the case manager must:

(1) provide the individual or LAR with a list of TAS provider agencies; and

(2) using the TAS Assessment and Authorization form, assist the individual or LAR to:

(A) identify the individual's essential needs for TAS; and

(B) provide estimated amounts for TAS items and services; and

(3) retain the completed TAS Assessment and Authorization form in the individual's record for inclusion on the enrollment IPC as described §42.214 of this chapter (relating to Development of Enrollment Individual Plan of Care (IPC)).

(f) The program provider must:

(1) gather and maintain the information necessary to process the individual's request for enrollment in the DBMD Program using forms prescribed by DADS in the *DBMD Program Manual*;

(2) assist the individual who does not have Medicaid financial eligibility or the individual's LAR to:

(A) complete an application for Medicaid financial eligibility; and

(B) submit the completed application to HHSC within 30 calendar days after the case manager's initial face-to-face, in-home visit;

(3) document in the individual's record any problems or barriers the individual or LAR encounters that may inhibit progress towards completing:

(A) the application for Medicaid financial eligibility; and

(B) enrollment in DBMD Program services; and

(4) assist the individual or LAR to overcome problems or barriers documented as described in paragraph (3) of this subsection.

(g) If an individual or LAR does not submit a completed Medicaid application to HHSC as described in subsection (f)(2)(B) of this section as a result of problems or barriers documented in subsection (f)(3) of this section but is making progress in collecting the documentation necessary for an application, the program provider may grant one or more 30 calendar day extensions.

(1) The program provider must ensure the case manager documents the rationale for an extension in the individual's record.

(2) The program provider must not issue an extension that will cause the period of Medicaid application preparation to exceed 12 months after the date of the case manager's initial face-to-face, in-home visit.

(3) The program provider must notify DADS DBMD program specialist in writing if the individual or LAR:

(A) fails to submit a completed Medicaid application to HHSC within 12 months after the date of the case manager's initial face-to-face, in-home visit; or

(B) does not cooperate with the case manager in completing the enrollment process described in this section.

(h) A program provider must ensure:

(1) the related conditions documented on the ID/RC Assessment form for the individual are on DADS Approved Diagnostic Codes for Persons with Related Conditions list contained in the *DBMD Program Manual*;

(2) the ID/RC Assessment is submitted to a physician for review; and

(3) the DADS Prior Authorization for Dental Services form is sent to a dentist as described in the *DBMD Program Manual* if the individual or LAR requests dental services other than an initial dental exam.

(i) After receiving the signed and dated ID/RC Assessment from the physician establishing that the individual meets the eligibility criteria described in §42.201(3) and (4) of this chapter (relating to Eligibility Criteria), the case manager must:

(1) convene a service planning team meeting within 10 business days after receipt of the signed and dated ID/RC Assessment; and

(2) if a DADS Prior Authorization for Dental Services form was submitted to a dentist as described in subsection (h)(3) of this section, ensure that the signed and completed form is available for the service planning team to review.

(j) During the service planning team meeting, the case manager must ensure:

(1) if the individual or LAR is requesting dental services other than an initial dental exam, the DADS Prior Authorization for Dental Services form has been signed by the dentist as described in §42.624(b) of this chapter (relating to Dental Treatment); ~~and~~

(2) an enrollment IPC is developed as described in §42.214 of this chapter; and ~~.~~

(3) if the enrollment IPC includes residential habilitation, nursing, or specialized nursing, that in accordance with §42.407 of this chapter (relating to Service Backup Plans), the service planning team determines whether the individual requires a service backup plan for residential habilitation, nursing, or specialized nursing services critical to the individual's health and safety and that a service backup plan is developed if needed.

(k) Within ten business days after the service planning team meeting, the case manager must:

(1) complete an enrollment Individual Program Plan (IPP) as described in §42.215 of this chapter (relating to Development of Enrollment Individual Program Plan (IPP));

~~(2) provide a copy of the completed enrollment IPC and IPP to the individual or LAR;~~

(2) ~~(3)~~ submit a request for enrollment to DADS for review as described in §42.216 of this chapter (relating to DADS Review of Request for Enrollment) that includes the following:

(A) a copy of the completed enrollment IPC;

(B) a copy of the ID/RC Assessment form signed by a physician;

(C) a copy of the completed enrollment IPP;

(D) a copy of the adaptive behavior screening assessment;

(E) a copy of the Related Conditions Eligibility Screening Instrument form;

(F) a copy of the DBMD Summary of Services Delivered form (for pre-assessment services) with supporting documentation;

(G) a copy of the Verification of Freedom of Choice, Waiver Program form;

(H) a copy of the Non-Waiver Services form;

(I) a copy of the Documentation of Provider Choice form;

(J) a copy of the DADS DBMD Nursing Assessment form; and

(K) [~~(J)~~] if applicable:

(i) Prior Authorization for Dental Services form;

(ii) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(iii) Provider Agency Model Service Backup Plan form; ~~Request for Authorization of IPP Over Cost Ceiling form~~;

(iv) Specialized Nursing Certification form;

(v) copies of letters of denial from non-waiver resources; and

(vi) TAS Assessment and Authorization form; and

~~(K) if requested by DADS, additional assessments and supporting documentation related to the individual's diagnosis; and~~

(3) ~~(4)~~ keep the original ID/RC Assessment signed by a physician in the individual's record.

(l) Within five business days after receiving a written notice from DADS approving or denying the individual's request for enrollment, the program provider must notify the individual or LAR of DADS decision. If DADS:

(1) approves the request for enrollment, the program provider must initiate DBMD Program services as described on the IPC; or

(2) denies the request for enrollment, the program provider must use the Denial of Application for DBMD Program form to notify the individual or LAR.

(m) The program provider must not provide DBMD Program services to an individual until notified by DADS that the individual's request for enrollment is approved. If a program provider provides DBMD Program services to an individual before the effective date of service approved by DADS, DADS does not reimburse the program provider for those services.

(n) Within ten business days after receiving a written notice from DADS approving the individual's request for enrollment, the program provider must provide to the individual or LAR a copy of the approved enrollment IPC and IPP, and if needed, the service backup plan.

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35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.214. Development of Enrollment Individual Plan of Care (IPC).

(a) The program provider must ensure that an individual's case manager convenes a service planning team meeting to develop, using person-directed planning, an enrollment IPC that includes ~~specifies~~:

(1) specific DBMD Program services;

(2) units of DBMD Program services;
(3) frequency of the services;
(4) if the individual will receive TAS, amounts for items and services to be paid through TAS identified in accordance with §42.212(e)(2) of this chapter (relating to Process for Enrollment of an Individual); ~~and~~

(5) an effective date of service that:
(A) is at least 10 business days after submission of the enrollment IPC to DADS as described in §42.212(k)(3) of this chapter; and
(B) does not overlap with the end date of another Medicaid waiver program or another DADS-operated program described in the *DBMD Program Manual* other than DAHS in which the individual may have been enrolled; and ~~.~~

(6) a determination whether the individual needs a service backup plan for residential habilitation, nursing, or specialized nursing services critical to the individual's health and safety.

(b) In addition to developing the enrollment IPC, the service planning team must identify non-waiver resources using the Non-Waiver Services form.
(c) For an enrollment IPC that includes adaptive aids, dental, minor home modifications, or respite, the program provider must ensure that the units for those services do not exceed the service limits described in Subchapter F of this chapter (relating to Service Descriptions and Requirements).
(d) The program provider must ensure that the DBMD Program services on the enrollment IPC:
(1) are necessary to protect the individual's health and welfare in the community;
(2) address at least one of the individual's related conditions or the additional disability that impairs independent functioning;
(3) supplement rather than replace the individual's natural supports and other non-waiver services and supports for which the individual is eligible;
(4) prevent the individual's admission to an institution;
(5) are the most appropriate type and amount of DBMD Program services to meet the individual's needs; and
(6) are cost effective.
(e) The program provider must:
(1) ensure that the enrollment IPC is signed and dated by each member of the service planning team;
(2) submit a copy of the enrollment IPC to DADS as described in §42.212(k) of this chapter; and
(3) maintain the original of the enrollment IPC in the individual's record.
(f) The program provider must maintain the following in the individual's record and provide copies to DADS upon request:
(1) current data obtained from standardized evaluations and formal assessments to support the individual's diagnoses in accordance §42.201(3) and (4) of this chapter (relating to Eligibility Criteria);
(2) documentation, including assessments of the individual, that support the DBMD Program services recommended on the IPC; and

(3) documentation that no other sources are available for DBMD Program services recommended on the IPC.

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§42.215. Development of Enrollment Individual Program Plan (IPP).

A case manager must:

(1) complete an enrollment IPP based on decisions made by the service planning team for the services listed on the enrollment IPC developed in accordance with §42.214 of this chapter (relating to Development of Enrollment Individual Plan of Care (IPC));

(2) ensure the enrollment IPP describes goals and objectives for each service listed on the IPC that:

(A) are supported by justifications;

(B) are outcome-based;

(C) are measurable; and

(D) have timelines; ~~and~~

(3) ensure the enrollment IPP includes:

(A) a description of the needs and preferences identified by the individual, LAR or both;

(B) a description of the services and supports the individual requires to continue living in a community-based setting;

(C) a description of the individual's current natural supports and non-waiver services that will be or are available;

(D) a description of the outcomes to be achieved through the DBMD Program services and justification for each service included in the IPC;

(E) documentation that the type, frequency, and amount of each DBMD Program service included in the IPP and IPC does not replace existing natural supports or non-waiver resources for which the individual may be eligible;

(F) a description of actions and methods to be used to reach identified service outcomes; and

(G) a statement whether the individual needs a service backup plan for residential habilitation, nursing, or specialized nursing services critical to the individual's health and safety; and

(4) ~~(3)~~ maintain the enrollment IPP in the individual's record.

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§42.216. DADS Review of Request for Enrollment.

(a) DADS reviews a request for enrollment submitted by a program provider in accordance with §42.212(k) of this division ~~chapter~~ (relating to Process for Enrollment of an Individual) to determine if:

(1) the individual meets the diagnostic eligibility criteria described in §42.201(2)-(4) of this subchapter (relating to Eligibility Criteria);

(2) the cost of the enrollment IPC meets the criteria described in §42.201(5) of this subchapter;

(3) the DBMD Program services specified in the enrollment IPC meet the requirements described in §42.214(d)(1)-(6) of this division ~~chapter~~ (relating to Development of Enrollment Individual Plan of Care (IPC)); and

(4) the goals and objectives described in the IPP for each DBMD Program service in the IPC meet the criteria described in §42.215(2)(A)-(D) of this division ~~chapter~~ (relating to Development of Enrollment Individual Program Plan (IPP)).

(b) ~~If requested by~~ To support the information in the enrollment IPC and IPP, DADS may request: ~~, the program provider must submit~~

(1) additional assessments and supporting documentation related to the individual's diagnosis; and ~~, including~~

(2) the documentation described in §42.214(f) of this division ~~chapter to support the information in the enrollment IPC and IPP~~.

(c) If DADS requests the information described in subsection (b) of this section, the case manager must submit the information to DADS within 10 calendar days after the date of the request.

(d) ~~(c)~~ DADS notifies the program provider, in writing, that the individual's request for enrollment is approved if:

(1) the request for enrollment meets the requirements described in subsection (a)(1)-(4) of this section;

(2) the individual is Medicaid-eligible due to receipt of SSI cash benefits or is determined by HHSC to be financially eligible for Medicaid; and

(3) the individual is not enrolled in a Medicaid waiver program other than the DBMD Program, or another DADS-operated program described in the *DBMD Program Manual*, other than DAHS.

(e) ~~(d)~~ DADS notifies the individual's program provider, in writing, that the individual's request for enrollment is denied if:

(1) the request for enrollment does not meet the requirements described in subsection (a)(1)-(4) of this section;

(2) the individual is not Medicaid-eligible due to receipt of SSI cash benefits or is determined by HHSC not to be financially eligible for Medicaid; or

(3) the individual is enrolled in a Medicaid waiver program other than the DBMD Program or another DADS-operated program described in the *DBMD Program Manual*, other than DAHS.

(f) ~~(e)~~ If DADS notifies the program provider that the individual's request for enrollment is denied, the program provider must send the individual or LAR written notice of the denial in accordance with §42.241(a)(2) of this subchapter (relating to Denial of Request for Enrollment in the DBMD Program or of a DBMD Program Service).

(g) ~~(f)~~ If DADS determines a DBMD Program service specified in the enrollment IPC does not meet the requirements described in §42.214(d)(1)-(6) ~~§42.214(b)(1)-(6)~~ of this division ~~chapter~~ or §42.215(2)(A)-(D) of this division ~~chapter~~, DADS:

(1) denies the service;

(2) modifies and authorizes the IPC;

(3) approves the individual's request for enrollment with the modified IPC; and

(4) notifies the program provider, in writing, of the action taken.

(h) ~~(g)~~ If DADS notifies the program provider of the denial of the DBMD Program service and of the modification of the enrollment IPC in accordance with subsection (f) of this section, the program provider must:

(1) implement the modified enrollment IPC; and

(2) send the individual or LAR written notice of the denial of DBMD Program service in accordance with §42.241(a)(2) of this subchapter.

(i) ~~(h)~~ DADS may approve the effective date of service as requested on the enrollment IPC or may modify the effective date of service.

(j) ~~(i)~~ DADS verification of diagnostic eligibility and approval of the enrollment IPC is valid for the IPC period of the enrollment IPC.

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§42.217. Consumer Directed Services (CDS) Option.

(a) The program provider must ensure an individual's case manager informs the individual or LAR:

(1) of the CDS option in accordance with Chapter 41, Subchapter D ~~§41.109~~ of this title (relating to Enrollment, Transfer, Suspension, and Termination ~~in the CDS Option~~);

(2) of the ~~specific~~ DBMD Program services ~~described in the Appendix C of the DBMD Program waiver application (available on the DBMD Program page of DADS website at www.dads.state.tx.us) for which~~ provided through the CDS option, as described in §41.108 of this title (relating to Services Available Through the CDS Option) ~~is available~~; and

(3) that the individual may elect to have one or more of those services provided through the CDS option.

(b) If the individual or LAR chooses to participate in the CDS option, the case manager must:

(1) provide the individual or LAR with an oral and written explanation of the CDS option using materials provided by DADS, including the required CDS forms described in Chapter 41 of this title (relating to Consumer Directed Services ~~(CDS)~~ Option);

(2) provide the individual or LAR with the name and contact information of each FMSA ~~CDSA~~ providing services in the county where the individual lives;

(3) document the individual's or LAR's choice of FMSA ~~CDSA~~ in accordance with DADS instructions;

(4) document each service to be provided through the CDS option on the IPC; and
(5) complete the required forms as described in Chapter 41 of this title.

(c) For services to be provided through the CDS option, the individual or LAR and the FMSA ~~CDSA~~ must comply with Chapter 41 of this title.

(d) The program provider must provide services included on the IPC that the individual or LAR has elected not to have provided through the CDS option.

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Division 3, Review
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§42.223. Periodic Review and Update of IPC and IPP.

(a) Case manager's quarterly review.

(1) At least every 90 calendar days after the effective date of service of an individual's IPC as determined in accordance with §42.216(h) of this subchapter ~~chapter~~ (relating to DADS Review of Request for Enrollment), the case manager must meet face-to-face with the individual or LAR at a time and place acceptable to the individual or LAR to:

(A) review whether the DBMD Program services are being provided as outlined in the IPC and IPP;

(B) review the individual's progress toward achieving the goals and objectives described in the IPP for each DBMD Program service;

(C) determine if the services are meeting the individual's needs;

(D) determine if the individual's needs have changed; ~~and~~

(E) review assessments, evaluations, and progress notes prepared by service providers since the previous quarterly review;~~.~~

(F) if the individual's IPC includes residential habilitation, nursing, or specialized nursing, and none of these services are identified as critical to meeting the individual's health and safety, discuss with the individual or LAR whether any of these services may now be critical to the individual's health and safety and needs a service backup plan; and

(G) if a service backup plan for residential habilitation, nursing, or specialized nursing services has been implemented, discuss the implementation of the service backup plan with the individual or LAR to determine whether or not the plan was effective.

(2) The case manager must:

(A) document the results of the quarterly review in the individual's record using the IPP quarterly review form; ~~and~~

(B) document in the IPP quarterly review form for an individual that has a service backup plan whether or not the service backup plan was:

(i) implemented;

(ii) effective; and

(iii) revised by the service planning team to address any problems or concerns regarding implementation of the service backup plan; and

(C) ~~(B)~~ provide a copy of the completed IPP quarterly review form to the individual or LAR within 10 business days after the date of the quarterly review.

(3) The case manager must convene a service planning team meeting within five business days after the date of the quarterly review meeting if the case manager:

(A) identifies needed changes in the individual's services; or

(B) determines that a residential habilitation, nursing, or specialized nursing service

may now be critical to the individual's health and safety, as described in paragraph (1)(F) of this subsection, or that the service backup plan was ineffective, as described in paragraph (1)(G) of this subsection.

(4) During a service planning team meeting described in paragraph (3) of this subsection, the case manager must:

(A) develop a revision IPC that meets the requirements described in §42.214(d)(1)-(6) of this subchapter (relating to Development of Enrollment Individual Plan of Care (IPC)); and

(B) develop a revision IPP that meets the requirements described in §42.215(2)(A)-(D) and (3)(A)-(G) of this subchapter (relating to Development and Enrollment Individual Program Plan (IPP)); and

(C) if the revision IPC includes residential habilitation, nursing, or specialized nursing services, ensure compliance with §42.407 of this chapter (relating to Service Backup Plans).

(5) The case manager must:

(A) ensure the revision IPC is signed and dated by each member of the service planning team; and

(B) within 10 business days after the date of the service planning meeting, submit to DADS:

(i) a copy of the completed revision IPC;
(ii) a copy of the revision IPP;
(iii) a copy of the most recent IPC approved by DADS;
(iv) if applicable:
(I) Specifications for Minor Home Modifications form;
(II) Prior Authorization for Dental Services form;
(III) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(IV) Provider Agency Model Service Backup Plan form;

(V) Specialized Nursing Certification form; and
(VI) adaptive behavior screening assessment.

~~(3) If the case manager identifies needed changes in the individual's services during the quarterly review meeting, the case manager must:~~
~~(A) convene a service planning team meeting within five business days after the date of the quarterly review meeting to develop a revision IPC and IPP;~~
~~(B) ensure the revision IPC is signed and dated by each member of the service planning team; and~~
~~(C) within 10 business days after the date of the service planning meeting, submit to DADS:~~
~~(i) a copy of the completed revision IPC;~~
~~(ii) a copy of the revision IPP;~~

~~(iii) a copy of the most recent IPC approved by DADS;~~
~~(iv) if applicable:~~
~~(I) Specifications for Minor Home Modifications form;~~
~~(II) Prior Authorization for Dental Services form;~~
~~(III) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;~~
~~(IV) Request for Authorization of IPP Over Cost Ceiling form;~~
~~(V) Specialized Nursing Certification form; and~~
~~(VI) adaptive behavior screening assessment; and~~
~~(v) if requested by DADS, additional assessments and supporting documentation related to the individual's diagnosis.~~
~~(4) The case manager must ensure:~~
~~(A) a revision IPC meets the criteria described in §42.214(d)(1)-(6) of this chapter (relating to Development of Enrollment Individual Plan of Care (IPC)); and~~
~~(B) a revision IPP meets the criteria described in §42.215(2)(A)-(D) of this chapter (relating to Development and Enrollment Individual Program Plan (IPP)).~~

(6) ~~(5)~~ DADS reviews the revision IPC in accordance with §42.221 of this division ~~chapter~~ (relating to Utilization Review of IPC by DADS) and may request additional assessments and supporting documentation related to the individual's diagnosis.

(7) If DADS requests the information described in paragraph (6) of this subsection, the case manager must submit the information to DADS within 10 calendar days after the date of the request.

(8) Within ten business days after receiving a written notice from DADS authorizing services on the revision IPC, the case manager must provide to the individual or LAR a copy of the revision IPC and revision IPP, and any new or revised service backup plan.

(9) ~~(6)~~ The program provider must electronically access the Medicaid Eligibility Service Authorization Verification (MESAV) ~~TMHP information~~ to verify that the services ~~requested~~ on the ~~a~~ revision IPC have been authorized by DADS ~~utilizing the Medicaid Eligibility Service Authorization Verification (MESAV)~~.

(b) Annual review by the service planning team.

(1) Within ~~At least annually, but within~~ 90 calendar days before the end of the IPC period:~~,~~

(A) an individual's case manager must convene a service planning team meeting to review the IPC and IPP; and ~~.~~

(B) a RN must complete an annual nursing assessment of the individual utilizing the DADS DBMD Nursing Assessment form.

(2) During the service planning team meeting:

(A) the ~~The~~ service planning team must:

(i) ~~(A)~~ develop a renewal IPC in accordance with §42.214(d)(1)-(6) of this subchapter and renewal IPP in accordance with §42.215(2)(A)-(D) and (3)(A)-(G) of this subchapter;

(ii) ~~(B)~~ complete a renewal ID/RC Assessment in accordance with the *DBMD Program Manual;*

(iii) if the renewal IPC includes residential habilitation, nursing, or specialized nursing services, ensure compliance with §42.407 of this chapter; and

(iv) ~~(C)~~ ensure the renewal IPC is signed and dated by each member of the service planning team; and

(B) the case manager must:

(i) orally and in writing explain all DBMD Program services to the individual or LAR;

(ii) explain to the individual, orally and in writing, the mandatory participation requirements of an individual as described in §42.252 of this subchapter (relating to Mandatory Participation Requirements of an Individual);

(ii) orally explain to the individual or LAR that the individual may transfer to a different program provider;

(iii) give the individual or LAR the Documentation of Provider Choice form for the DADS region in which the individual resides;

(iv) orally explain to the individual or LAR that they may request the provision of residential habilitation, nursing, case management, out-of-home respite in a camp, adaptive aids, or intervener services while the individual is temporarily staying at a location outside the program provider's contracted service delivery area but within the state of Texas during a period of no more than 60 consecutive days;

(v) orally explain to the individual or LAR the individual's rights and responsibilities, including the right to request a Medicaid Fair Hearing as described in §42.251 of this chapter (relating to Individual's Right to a Fair Hearing);

(vi) explain to the individual or LAR the procedures for an individual or LAR to file a complaint regarding a DBMD Program provider;

(vii) orally explain the CDS option to the individual or LAR as described in §42.217 of this subchapter (relating to Consumer Directed Services (CDS) Option);

(viii) explain orally and in writing to the individual or LAR procedures for reporting an allegation of abuse, neglect, and exploitation;

(ix) have documentation that the oral explanation and information required under subparagraphs (C)-(K) of this paragraph were provided; and

(x) orally explain to the individual or LAR that the individual may request a service planning team meeting to discuss the reason the provider declined the request to provide services outside the program provider's contracted service delivery area.

(3) ~~(D)~~ The case manager must within 10 business days after the date of the service planning meeting but at least 30 calendar days before the end of the current IPC period, submit to DADS:

(A) ~~(i)~~ a copy of the completed renewal IPC;
(B) ~~(ii)~~ a copy of the most recent IPC approved by DADS;
(C) ~~(iii)~~ a copy of the ID/RC Assessment;
(D) ~~(iv)~~ a copy of the renewal IPP;
(E) ~~(v)~~ a copy of the Related Conditions Eligibility Screening Instrument;
(F) ~~(vi)~~ a copy of the Non-Waiver Services form;
(G) ~~(vii)~~ a copy of the Documentation of Provider Choice form; ~~and~~
(H) a copy of the DADS DBMD Nursing Assessment form; and

(I) ~~(viii)~~ if applicable:

(i) ~~(I)~~ an adaptive behavior screening assessment if the last assessment occurred five years prior or if significant changes have occurred;

(ii) ~~(II)~~ Specifications for Minor Home Modifications form;

(iii) ~~(III)~~ Prior Authorization for Dental Services form;

(iv) ~~(IV)~~ Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(v) ~~(V)~~ Provider Agency Model Service Backup Plan form ~~Request for Authorization of IPP Over Cost Ceiling form~~; and

(vi) ~~(VI)~~ Specialized Nursing Certification form. ~~;and~~

~~(ix) if requested by DADS, additional assessments and supporting documentation related to the individual's diagnosis.~~

~~(3) The case manager must:~~

~~(A) ensure the renewal IPC meets the criteria described in §42.214(d)(1)-(6) of this chapter;~~

~~(B) ensure the renewal IPP meets the criteria described in §42.215(2)(A)-(D) of this chapter;~~

~~(C) orally and in writing explain all DBMD Program services to the individual or LAR;~~

~~(D) explain to the individual, orally and in writing, the mandatory participation requirements of an individual as described in §42.252 of this chapter (relating to Mandatory Participation Requirements of an Individual);~~

~~(E) orally explain to the individual or LAR that the individual may transfer to a different program provider;~~

~~(F) give the individual or LAR the Documentation of Provider Choice form for the DADS region in which the individual resides;~~
~~(G) orally explain to the individual or LAR that they may request the provision of residential habilitation, nursing, case management, out-of-home respite in a camp, adaptive aids, or intervener services while the individual is temporarily staying at a location outside the program provider's contracted service delivery area but within the state of Texas during a period of no more than 60 consecutive days;~~
~~(H) orally explain to the individual or LAR the individual's rights and responsibilities, including the right to request a Medicaid Fair Hearing as described in §42.251 of this chapter (relating to Individual's Right to a Fair Hearing);~~
~~(I) explain to the individual or LAR the procedures for an individual or LAR to file a complaint regarding a DBMD~~ Program provider;
~~(J) orally explain the CDS option to the individual or LAR as described in §42.217 of this chapter (relating to Consumer Directed Services (CDS) Option);~~
~~(K) explain orally and in writing to the individual or LAR procedures for reporting an allegation of abuse, neglect, and exploitation;~~
~~(L) have documentation that the oral explanation and information required under subparagraphs (C)-(K) of this paragraph were provided; and~~
~~(M) orally explain to the individual or LAR that the individual may request a service planning team meeting to discuss the reason the provider declined the request to provide services outside the program provider's contracted service delivery area.~~

(4) DADS ~~reviews~~:

(A) reviews:

(i) the renewal IPC in accordance with §42.221 of this division ~~chapter~~; and

(ii) ~~(B)~~ the renewal ID/RC Assessment in accordance with §42.222 of this division ~~chapter~~ (relating to Annual Review and Reinstatement of Lapsed Diagnostic Eligibility); and ~~.~~

(B) may request additional assessments and supporting documentation related to the individual's diagnosis.

(5) If DADS requests the information described in paragraph (4)(B) of this subsection, the case manager must submit the information to DADS within 10 calendar days after the date of the request.

(6) Within ten business days after receiving a written notice from DADS authorizing services on the renewal IPC, the case manager must provide to the individual or LAR a copy of the renewal IPC and renewal IPP, and any new or revised service backup plan.

(7) ~~(5)~~ The program provider must electronically access the Medicaid Eligibility Service Authorization Verification (MESAV) ~~TMHP information~~ to verify that the services ~~requested~~ on the ~~a~~ renewal IPC have been authorized by DADS ~~utilizing the Medicaid Eligibility Service Authorization Verification (MESAV)~~.

(c) Review and revision in an emergency.

(1) If a program provider delivers a DBMD Program service to an individual in an emergency to ensure the individual's health and welfare and the service is not on the IPC and IPP or exceeds the amount on the IPP, the case manager ~~program provider~~ must:

(A) within five business days after providing the service, convene a service planning team meeting to review and revise the IPC in accordance with §42.214(d)(1)-(6) of this subchapter and a revision IPP in accordance with §42.215(2)(A)-(D) and (3)(A)-(G) of this subchapter and ~~, to~~ include on the revision IPP, documentation of how the requested services addressed the emergency;

(B) if the revision IPC includes residential habilitation, nursing, or specialized nursing services, ensure compliance with §42.407 of this chapter;

(C) ~~(B)~~ ensure the revision IPC is signed and dated by each member of the service planning team; and

(D) ~~(C)~~ within 10 business days after the service planning meeting, submit to DADS:

(i) a copy of the completed revision IPC;

(ii) a copy of the revision IPP;

(iii) a copy of the most recent IPC approved by DADS; and

(iv) if applicable:

(I) Specifications for Minor Home Modifications form;

(II) Prior Authorization for Dental Services form;

(III) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(IV) Provider Agency Model Service Backup Plan form ~~Request for Authorization of IPP Over Cost Ceiling form~~;

(V) Specialized Nursing Certification form; and

(VI) adaptive behavior screening assessment. ~~;and~~

~~(v) if requested by DADS, additional assessments and supporting documentation related to the individual's diagnosis.~~

~~(2) The case manager must ensure:~~

~~(A) a revision IPC meets the criteria described in §42.214(b)(1)-(6) of this chapter; and~~

~~(B) a revision IPP meets the criteria described in §42.215(2)(A)-(D) of this chapter.~~

(2) ~~(3)~~ DADS:

(A) reviews the revision IPC in accordance with §42.221 of this division; and ~~chapter.~~

(B) may request additional assessments and supporting documentation related to the individual's diagnosis.

(3) If DADS requests the information described in paragraph (2)(B) of this subsection, the case manager must submit the information to DADS within 10 calendar days after the date of the

request.

(4) Within ten business days after receiving a written notice from DADS authorizing services on the revision IPC, the case manager must provide to the individual or LAR a copy of the revision IPC and revision IPP, and any new or revised service backup plan.

(5) ~~(4)~~ The program provider must electronically access the Medicaid Eligibility Service Authorization Verification (MESAV) ~~TMHP information~~ to verify that the services ~~requested~~ on the ~~a~~ revision IPC have been authorized by DADS ~~utilizing the Medicaid Eligibility Service Authorization Verification (MESAV)~~.

(d) Review and change other than quarterly, annually, or in an emergency.

(1) If a program provider becomes aware at any time during an individual's IPC period that changes to the individual's services may be necessary, the individual's case manager must:

(A) within five business days after becoming aware that changes to the individual's services may be necessary, convene a service planning team meeting to review and, if determined necessary, revise the IPC in accordance with §42.214(d)(1)-(6) of this subchapter and IPP in accordance with §42.215(2)(A)-(D) and (3)(A)-(G) of this subchapter;

(B) if the revision IPC includes residential habilitation, nursing, or specialized nursing services, ensure compliance with §42.407 of this chapter;

(C) ~~(B)~~ ensure the revised IPC is signed and dated by each member of the service planning team; and

(D) ~~(C)~~ within 10 business days after the date of the service planning meeting, submit the following to DADS:

(i) a copy of the completed revision IPC;
(ii) a copy of the revision IPP;
(iii) a copy of the most recent IPC approved by DADS; and
(iv) if applicable:
(I) Specifications for Minor Home Modifications form;
(II) Prior Authorization for Dental Services form;
(III) Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications form;

(IV) Provider Agency Model Service Backup Plan form; ~~Request for Authorization of IPP Over Cost Ceiling form~~;

(V) Specialized Nursing Certification form; and
(VI) adaptive behavior screening assessment.

~~; and~~
~~(v) if requested by DADS, additional assessments and supporting documentation related to the individual's diagnosis.~~
~~(2) The case manager must ensure:~~

~~(A) a revision IPC meets the criteria described in §42.214(b)(1)-(6) of this chapter; and~~
~~(B) a revision IPP meets the criteria described in §42.215(2)(A)-(D) of this chapter.~~

(2) ~~(3)~~ DADS:

(A) reviews the revision IPC in accordance with §42.221 of this division; and ~~chapter.~~

(B) may request additional assessments and supporting documentation related to the individual's diagnosis.

(3) If DADS requests the information described in paragraph (2)(B) of this subsection, the case manager must submit the information to DADS within 10 calendar days after the date of the request.

(4) Within ten business days after receiving a written notice from DADS authorizing services on the revision IPC, the case manager must provide to the individual or LAR a copy of the revision IPC and revision IPP, and any new or revised service backup plan.

(5) ~~(4)~~ The program provider must electronically access the Medicaid Eligibility Service Authorization Verification (MESAV) ~~TMHP information~~ to verify that the services ~~requested~~ on the ~~a~~ revision IPC have been authorized by DADS ~~utilizing the Medicaid Eligibility Service Authorization Verification (MESAV)~~.

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter B, Eligibility, Enrollment, and Review
Division 5, Denial, Suspension, Reduction, and Termination
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.242. Suspension of DBMD Program Services ~~With Advance Notice~~.

(a) Except as described in §42.232 of this chapter (relating to Personal Leave for Individual Receiving Licensed Assisted Living or Licensed Home Health Assisted Living) or if the individual receives out-of-home respite, DADS suspends an individual's DBMD Program services if the individual:

(1) is admitted to one of the following facilities for 180 consecutive calendar days or less:

(A) an ICF/IID ~~ICF/MR~~;

(B) a nursing facility licensed or subject to being licensed in accordance with Texas Health and Safety Code, Chapter 242;

(C) an assisted living facility (ALF) in which more than six ~~or more other~~ persons reside;

(D) a residential child-care operation licensed or subject to being licensed by DFPS unless it is a foster family home or a foster group home;

(E) a facility licensed or subject to being licensed by the Department of State Health Services (DSHS);

(F) a residential facility operated by the Texas Youth Commission; or

(G) a jail or prison; or

(2) leaves the state for 180 consecutive calendar days or less.

(b) If an individual receiving licensed assisted living facility or licensed home health assisted living is admitted to one of the facilities listed in subsection (a)(1) of this section, the program provider:

(1) must hold the individual's bed for at least 60 consecutive calendar days and may charge the individual or representative for room and board for each of the 60 calendar days the program provider holds the bed; or ~~day~~

(2) if the program provider holds the individual's bed for more than 60 consecutive calendar days, the program provider may charge the individual or representative for room and board for holding the bed up to 180 consecutive calendar days.

~~up to 180 consecutive calendar days that the individual is at the facility ; and~~

~~(2) must hold the individual's bed for up to 60 consecutive calendar days.~~

(c) The suspension period is the length of the individual's admission to the facility or the time the individual spends outside the state up to 180 consecutive calendar days.

(d) Within five business days after becoming aware that a situation described in subsection (a) of this section exists, the program provider must request, in writing, that DADS suspend DBMD Program services for the individual.

(1) The program provider must send supporting documentation with the request.

(2) If DADS suspends an individual's DBMD Program services because the individual is admitted to a facility listed in subsection (a)(1) of this section, the program provider may request DADS authorization to continue ~~continuation of~~ one or more DBMD Program services.

(A) Before delivering the DBMD Program services, the program provider must submit the request and documentation to DADS that the absence of the DBMD Program services would constitute a threat to the individual's health and welfare.

(B) DADS notifies the program provider in writing if it approves continuation of the service.

(C) If DADS approves continuation of the DBMD Program service, DADS reimburses the program provider for provision of that service.

~~(3) The program provider must coordinate with the facility including active involvement by the DBMD Program case manager in discharge planning and related transition activities on behalf of the individual, including attendance at meetings held at the facility.~~

(e) DADS sends a written notice with the effective date of the suspension to the program provider that the program provider, upon receipt, must send to the individual or LAR, copying the FMSA ~~CDSA~~, if applicable.

(f) During the suspension, the program provider must coordinate with the facility including active involvement by the DBMD Program case manager in discharge planning and related transition activities on behalf of the individual, including attendance at meetings held at the facility.

(g) ~~(f)~~ If the individual or LAR requests a fair hearing, the program provider is not required to provide services to the individual while the appeal is pending.

(h) ~~(g) If an individual's suspension period will exceed 180 consecutive calendar days,~~ DADS may, under extenuating circumstances, approve one or more 30 calendar day extensions of the180 consecutive calendar days suspension period if the individual anticipates resuming participation in DBMD Program services during the period of the extension.

(i) To request an extension as provided in subsection (h) of this section, a program provider must:

(1) submit the request in writing to DADS; and

(2) include documentation of the extenuating circumstances.

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter C, Program Provider Enrollment
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.301. Program Providers.

~~(a)~~ A program provider ~~person or legal entity~~ must comply with ~~follow the procedures described in~~ Chapter 49 of this title (relating to Contracting for Community Services ~~Care~~) ~~to become a program provider~~.
~~(b) A program provider must comply with applicable provisions of Chapter 49 of this title to retain its contract to provide DBMD Program services.~~

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter D, Additional Program Provider Provisions
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.401. Protection of Individual.

(a) The program provider must have and implement written human resource policies and procedures that safeguard an individual against:

(1) infectious and communicable diseases;

(2) conflicts of interest with service providers;

(3) acts of financial impropriety on the part of the program provider or service providers;

and

~~(4) abuse, neglect, and exploitation; and~~

(4) ~~(5)~~ deliberate damage of personal possessions by the program provider or service providers.

(b) A program provider must not use seclusion.

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter D, Additional Program Provider Provisions
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.402. Staff Qualifications.

(a) A program provider must employ a program director who is responsible for the program provider's day-to-day operations. The program director must:

(1) have a minimum of one year of paid experience in community programs planning and providing direct services to individuals with deafness, blindness, or multiple disabilities and have a master's degree in a health and human services related field;

(2) have a minimum of two years of paid experience in community programs planning and providing direct services to individuals with deafness, blindness, or multiple disabilities, and have a bachelor's degree in a health and human services related field; or

(3) have been the program director for a DBMD Program provider on or before June 15, 2010.

(b) A program provider must ensure that a case manager:

(1) has:

(A) a bachelor's degree in a health and human services related field and a minimum of two years of experience in the delivery of direct services to individuals with disabilities;

(B) an associate's degree in a health and human services related field and a minimum of four years of experience providing direct services to individuals with disabilities; or

(C) a high school diploma or certificate recognized by a state as the equivalent of a high school diploma and a minimum of six years of experience providing direct services to individuals with disabilities; and

(2) either:

(A) is fluent in the communication methods used by an individual to whom the case manager is assigned (for example American sign language, tactile symbols, communication boards, pictures, and gestures); or

(B) within six months after being assigned to an individual, becomes fluent in the communication methods used by the individual.

(c) For purposes of subsection (d) of this section and consistent with Texas Government Code, §531.0973, "deafblind-related course work" means educational courses designed to improve a person's:

(1) knowledge of deafblindness and its effect on learning;

(2) knowledge of the role of intervention and ability to facilitate the intervention process;

(3) knowledge of areas of communication relevant to deafblindness, including methods, adaptations, and use of assistive technology, and ability to facilitate the development and use of communication skills for a person with deafblindness;

(4) knowledge of the effect that deafblindness has on a person's psychological, social, and emotional development and ability to facilitate the emotional well-being of a person with deafblindness;

(5) knowledge of and issues related to sensory systems and ability to facilitate the use of the senses;

(6) knowledge of motor skills, movement, orientation, and mobility strategies and ability to facilitate orientation and mobility skills;

(7) knowledge of the effect that additional disabilities have on a person with deafblindness and the ability to provide appropriate support; or

(8) professionalism and knowledge of ethical issues relevant to the role of an intervener.

(d) A program provider must ensure that:

(1) an intervener:

(A) is at least 18 years of age;

(B) is not the spouse of the individual to whom the intervener is assigned;

(C) holds a high school diploma or a high school equivalency certificate;

(D) has a minimum of two years of experience working with individuals with developmental disabilities; and

(E) has the ability to proficiently communicate in the functional language of the individual to whom the intervener is assigned;

(2) an intervener I:

(A) meets the requirements for an intervener as described in paragraph (1) of this subsection;

(B) has a minimum of six months of experience working with persons who have deafblindness or function as persons with deafblindness;

(C) has completed a minimum of eight semester credit hours in deafblind-related course work at a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education;

(D) a one-hour practicum in deafblind-related course work at a college or university accredited by a state agency or a non-governmental entity recognized by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education;

(3) an intervener II:

(A) meets the requirements of an intervener I as described in paragraph (2)(A), (C), and (D) of this subsection;

(B) has a minimum of nine months of experience working with persons who have deafblindness or function as persons with deafblindness; and

(C) has completed an additional 10 semester credit hours in deafblind-

related course work at a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education; and

(4) an intervener III:

(A) meets the requirements of an intervener II as described in paragraph (3)(A) of this subsection;

(B) has a minimum of one year of experience working with persons with deafblindness; and

(C) holds an associate's or bachelor's degree in a course of study with a focus on deafblind-related course work from a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education;

(e) A program provider must ensure that a service provider who interacts directly with an individual is able to communicate with the individual.

(f) A program provider must ensure that a service provider of a therapy described in §42.632(a) of this chapter (relating to Therapies) is licensed by the State of Texas as described in §42.632(b) of this chapter.

(g) A service provider of employment assistance and a service provider of supported employment must be at least 18 years of age, not be the individual's LAR, and have:

(1) a bachelor's degree in rehabilitation, business, marketing, or a related human services field with one year's paid or unpaid experience providing employment services to people with disabilities;

(2) an associate's degree in rehabilitation, business, marketing, or a related human services field with two years' paid or unpaid experience providing employment services to people with disabilities; or

(3) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, with three years' paid or unpaid experience providing employment services to people with disabilities.

(h) Documentation of the experience required by subsection (g) of this section must include:

(1) for paid experience, a written statement from a person who paid for the service or supervised the provision of the service; and

(2) for unpaid experience, a written statement from a person who has personal knowledge of the experience.

(i) ~~(g)~~ A program provider must ensure that a service provider not required to meet the other education or experience requirements described in this section:

(1) is 18 years of age or older;

(2) has:

(A) a high school diploma;

(B) a certificate recognized by a state as the equivalent of a high school diploma; or

(C) the following:

(i) documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment; and

(ii) at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual; and

(3) except for a service provider of chore services, either:

(A) is fluent in the communication methods used by the individual to whom the service provider is assigned (for example American sign language, tactile symbols, communication boards, pictures, and gestures); or

(B) has the ability to become fluent in the communication methods used by an individual within three months after being assigned to the individual.

(j) ~~(h)~~ The program provider must ensure that:

(1) a vehicle in which a service provider transports an individual has a valid Vehicle Identification Certificate of Inspection, in accordance with state law; and

(2) a service provider who transports an individual in a vehicle has:

(A) a current Texas driver's license; and

(B) vehicle liability insurance, in accordance with state law.

(k) ~~(i)~~ The program provider must maintain documentation in a service provider's employment, contract, or personal service agreement file that the service provider meets the requirements of this section.

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Subchapter D, Additional Program Provider Provisions
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.403. Training.

(a) A program provider must ensure that a program director and all service providers complete ~~have~~ a general orientation curriculum before assuming duties and annually. The general orientation curriculum must include training in ~~that addresses~~:

(1) the rights of an individual;

(2) confidentiality;

(3) abuse, neglect, and exploitation; and

(4) the program provider's complaint process.

(b) A program provider must ensure that, before assuming duties, a program director and a

service provider of a service ~~case manager, intervener, or a service provider~~ other than behavioral support, chore services, orientation and mobility, nursing, specialized nursing, or a therapy ~~a licensed or certified professional~~

~~(1)~~ completes and has current documentation of completion of ~~having successfully completed~~ hands-on skills training in:

(1) ~~(A)~~ cardiopulmonary resuscitation (CPR);

(2) ~~(B)~~ first aid; and

(3) ~~(C)~~ choking prevention.

~~(2) completes the program provider's general orientation curriculum described in subsection (a) of this section.~~

(c) A program provider must:

(1) ensure that a service provider required to complete hands-on skills training in accordance with subsection (b) ~~(b)(1)~~ of this section periodically updates hands-on skills training in accordance with guidelines of the training organization; and

(2) maintain a copy of current training documentation in the service provider's file.

(d) A program provider must ensure that a person who is a program director or case manager completes, within six months after assuming job duties:

(1) the DBMD Program case management training provided by DADS or training developed by the program provider that addresses the following elements from the DADS DBMD Program case management curriculum;

(A) the DBMD Program service delivery model:

(i) role of the case manager and DBMD Program provider;

(ii) role of the service planning team;

(iii) person-directed planning; and

(iv) the CDS option;

(B) DBMD Program services, including how these services:

(i) complement other Medicaid services;

(ii) supplement family supports and non-waiver services available in the individual's community; and

(iii) prevent institutionalization;

(C) DBMD Program process and procedures for:

(i) eligibility and enrollment;

(ii) service planning, service authorization, and program plans;

(iii) access to non-waiver resources; and

(iv) complaint procedures and the fair hearing process; and

(D) rules, policies, and procedures about:

(i) prevention of abuse, neglect, and exploitation of an individual;
(ii) reporting abuse, neglect, and exploitation to local and state authorities; and
(iii) financial improprieties toward an individual; and

(2) the Service Provider Curriculum required by DADS as described in subsection (e) of this section, if providing direct services to an individual.

(e) A program provider must ensure a service provider of a service other than behavioral support, chore services ~~chores~~, orientation and mobility, or a therapy:

(1) completes, within 90 calendar days after assuming job duties, the Service Provider Training provided by DADS or training developed by the program provider that addresses the following elements from the DADS Service Provider Training curriculum:

(A) methods and strategies for communication;
(B) active participation in home and community life;
(C) orientation and mobility;
(D) behavior as communication;
(E) causes and origins of deafblindness; and
(F) vision, hearing, and the functional implications of deafblindness; and
~~(G) delegated tasks;~~

(2) who has not completed the Service Provider training is accompanied at all times while providing services to an individual by a service provider who has completed Service Provider Training. ~~; and~~

(f) ~~(3)~~ A program provider must ensure a service provider of a service other than behavioral support, case management, chore services, orientation and mobility, nursing, specialized nursing, or a therapy, before providing direct services to an individual, annually, and as the individual's needs change, completes specific training that includes ~~the following~~:

(1) ~~(A)~~ the special needs of the individual, ~~to include~~ including the individual's:

(A) ~~(i)~~ methods of communication;

(B) ~~(ii)~~ specific visual and audiological loss; and

(C) ~~(iii)~~ adaptive aids; and
~~(iv) behavioral habits and cautions; and~~
~~(v) specific service tasks; and~~

(2) ~~(B)~~ managing challenging behavior, including training in:

(A) prevention of aggressive behavior; and

(B) de-escalation techniques; and

(3) ~~(B)~~ instruction in the individual's home with full participation by the individual, LAR, or other involved persons, as appropriate, concerning the specific tasks to be performed.

(g) ~~(f)~~ If a program provider develops training based on DADS curriculum as described subsections (d)(1) or (e)(1) of this section, the program provider must ensure that the instructor who delivers the training completed the appropriate training provided by DADS.

(h) ~~(g)~~ The program provider must ensure a service provider performing a delegated task is trained before providing direct services to an individual, annually, and as the individual's needs change, and supervised by a physician or nurse, as appropriate, in compliance with applicable state law and rules.

(i) ~~(h)~~ The program provider must document the training described in subsections ~~(c) and~~ (d) and (e) of this section by a certificate or form letter that includes the:

(1) name of the person who received the training;

(2) date(s) the training was completed; and

(3) name of the person certifying the completion of the course.

(j) A program provider must ensure compliance with the training and training documentation requirements described in §42.408(d)(2) of this subchapter (relating to Protective Devices).

(k) A program provider must ensure compliance with the training and training documentation requirements described in §42.409(c)(4) of this subchapter (relating to Restraints).

~~(i) The program provider must ensure that each service provider completes the training described in subsections (e)(3) and (g) of this section, as appropriate, annually and as the individual's needs change.~~

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Subchapter D, Additional Program Provider Provisions
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§**42.404. Service Delivery.**

(a) A program provider must ensure that:

(1) a full-time case manager is assigned to provide case management services to no more than 30 individuals or other persons receiving services through another Medicaid waiver at one time; and

(2) a part-time case manager is assigned to provide case management services to no more than 15 individuals or other persons receiving services through another Medicaid waiver at one time.

(b) In determining the number of individuals or other persons receiving services through another Medicaid waiver at one time to whom a case manager will be assigned, the program provider must take into consideration:

(1) the intensity of needs of each individual or person;

(2) the frequency and duration of contacts the case manager will need to make with the individual or person; and

(3) the amount of travel time involved in making such contacts.

(c) A program provider must have:

(1) a sufficient number of case managers available at all times to ensure the provision of case management services; and

(2) a written process that ensures a case manager can readily become familiar with an individual to whom the case manager is not ordinarily assigned but to whom the case manager may be required to provide case management services.

(d) A program provider must have written policies ~~polices~~ and procedures that ensure back-up staff are or can readily become familiar with individuals to whom they are not ordinarily assigned but to whom they may be required to deliver services.

(e) A program provider must provide each DBMD Program service authorized in an individual's IPC in accordance with:

(1) the individual's current IPC;

(2) the individual's current IPP; and

(3) the requirements in this chapter.

(f) A program provider must provide or ensure the provision of each DBMD Program service listed in §42.104(d) of this chapter (relating to Description of Deaf Blind with Multiple Disabilities (DBMD) Waiver Program). A program provider must provide the assisted living service as either licensed assisted living or licensed home health assisted living in accordance with §42.630 of this chapter (relating to Residential Services).

(g) ~~(f)~~ A program provider must offer an individual choices and opportunities for accessing and participating in community activities, including employment opportunities and experiences available to peers without disabilities, and provide supports necessary for the individual to participate in such activities consistent with an individual's or LAR's choice and the individual's IPC and IPP.

(h) If a program provider or case manager is unable to meet a timeframe specified in this chapter, it must be for a reason not directly caused by the program provider or case manager, or for a reason beyond the program provider's or case manager's control, such as a man-made or natural disaster. The program provider or case manager must document the program provider's or case manager's efforts to meet a timeframe and maintain the documentation in the individual's record. The documentation must include:

(1) the reason the timeframe could not be met, which must be beyond the program provider's or case manager's control; and

(2) a description of the program provider's or case manager's ongoing efforts to meet a timeframe.

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35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.405. Recordkeeping Requirements.

~~(a) A program provider must:~~
~~(1) ensure the following documentation is readily accessible and retrievable for review by DADS representatives and all applicable federal and state agencies or their representatives;~~
~~(A) service delivery records and supporting documents; and~~
~~(B) financial records and supporting documents; and~~
~~(2) allow DADS and all applicable federal and state agencies or their representatives to make copies of any contract-related service delivery records and supporting documentation at no charge.~~

(a) ~~(b)~~ A program provider must ensure that an individual's record includes the following:

(1) the individual's current IPC and each revision IPC for the current IPC period;

(2) the individual's current IPP and each revision IPP for the current IPC period;

(3) the individual's current ~~MR/RC~~ ID/RC Assessment and the last ~~MR/RC~~ ID/RC Assessment signed by a physician or, if applicable, the last level of care form signed by a physician;

(4) current adaptive behavior screening assessment;

(5) Summary of Services Delivered form completed as described in the *DBMD Program Manual*;

(6) any other relevant documentation supporting services on the IPC;

(7) documentation of the progress or lack of progress in achieving goals or outcomes in observable, measurable terms that directly relate to the specific goal or objective addressed to include:

(A) assessments, evaluations, and progress notes submitted to a case manager by a service provider for review in accordance with §42.223(a)(1)(E) of this chapter (relating to Periodic Review and Update of IPC and IPP); and

(B) the IPP quarterly reviews for the current IPC period prepared by a case manager in accordance with §42.223(a)(2) of this chapter;

(8) the Verification of Freedom of Choice form documenting the individual's or LAR's choice of services; ~~and~~

(9) the Documentation of Provider Choice form documenting the individual's or LAR's choice of a program provider; and ~~.~~

(10) if applicable, any new or revised Provider Agency Model Service Backup Plan form for residential habilitation, nursing, or specialized nursing for the current IPC period.

(b) ~~(c)~~ In addition to the requirements in subsection (a) of this section, a ~~A~~ program provider must ensure a service provider documents service activities in the individual's record, including:

(1) the date, time service activities begin and end, and duration of contact;

(2) type of contact (phone or face-to-to face);

(3) the person with whom the contact occurred;

(4) ~~the~~ a description of the service ~~activity~~ activities provided, unless the service activity provided is a non-delegated task provided by unlicensed staff that is documented on the IPP; and

(5) the signature and title of the service provider.

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35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.406. Quality Assurance.

(a) A program provider must conduct an annual survey of individuals, LARs, and actively involved family members and friends to determine satisfaction with services.

~~(b) A program provider must have and implement written policies and procedures to address receipt of and response to formal and informal complaints by an individual or LAR.~~

(b) A program provider must not terminate or otherwise retaliate against:

(1) a service provider, individual, or other person, because a service provider, individual, or other person, files a complaint, presents a grievance, or otherwise provides good faith information relating to the:

(A) misuse of restraint by the program provider; or

(B) use of seclusion by the program provider; or

(2) an individual because someone on behalf of the individual files a complaint, presents a grievance, or otherwise provides good faith information relating to the:

(A) misuse of restraint by the program provider; or

(B) use of seclusion by the program provider.

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~~**§42.407. E-mail Notification.**~~
~~A program provider must subscribe to receive e-mail notifications regarding the DBMD Program by entering information on DADS' website at www.dads.state.tx.us.~~

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter D, Additional Program Provider Provisions

§42.407 Service Backup Plans.

(a) If an individual's IPC includes residential habilitation, nursing, or specialized nursing, the case manager must ensure that the service planning team determines if an individual needs a service backup plan or a service backup plan revision during:

(1) the process of enrollment described in §42.212 of this chapter (relating to Process for Enrollment of an Individual);

(2) each of the reviews described in §42.223 of this chapter (relating to Periodic Review and Update of IPC and IPP); and

(3) an individual's transfer from one program provider to another.

(b) If the service planning team determines that an individual needs a service backup plan for residential habilitation, nursing, or specialized nursing services critical to the individual's health and safety, the case manger must:

(1) document on the individual's IPC and IPP the residential habilitation, nursing, or specialized nursing services that require a service backup plan;

(2) develop with input from the service planning team the service backup plan for each service identified as critical using the Provider Agency Model Service Backup Plan form; and

(3) ensure that:

(A) the service backup plan addresses emergencies, including when the failure of a service provider to appear as scheduled presents a risk to an individual's health and welfare; and

(B) if the action in the service backup plan identifies a natural support, that the natural support receives pertinent information about the individual's needs and is able to protect the individual's health and safety.

(c) If the service backup plan is implemented, the service planning team must revise the service backup plan for residential habilitation, nursing, or specialized nursing to address any

problems or concerns from the individual, case manager, service provider, or natural support regarding implementation of the service backup plan.

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter D, Additional Program Provider Provisions

§42.408 Protective Devices.

(a) Except as allowed in §42.409 of this subchapter (relating to Restraints), the only type of restrictive intervention a program provider may use is a protective device for the purpose of protecting or positioning an individual in specific circumstances.

(b) A program provider must not use a protective device to control an individual's behavior, for disciplinary purposes, for convenience, or as a substitute for effective assistance.

(c) Before a program provider uses a protective device, the program provider must:

(1) attempt less restrictive methods;

(2) document in the individual's case record the less restrictive methods attempted and failure of the methods;

(3) have a registered nurse conduct an assessment of the individual's needs;

(4) obtain a physician's order for the use of a protective device and instructions on how and when to use it;

(5) obtain and retain in the individual's case record written consent of the individual or LAR to use a protective device;

(6) provide oral and written notification to the individual or LAR of the right at any time to withdraw consent for the use of the protective device;

(7) have a registered nurse, with input from the individual's service planning team, and other professional personnel, develop a written service plan for the use of a protective device that describes:

(A) the type of device and the circumstances under which it may be used;

(B) how to implement the physician's orders;

(C) how and when to document the use of the protective device;

(D) how to monitor the protective device;

(E) when and whom the program staff must notify of a protective device's use;

(F) the method and content of the training required to use the protective device; and

(G) the frequency for providing the training, which must be:

(i) before a service provider uses the protective device;
(ii) annually; and
(iii) each time the individual's needs related to the protective device changes; and

(8) ensure the service planning team approves the service plan in writing.

(d) A program provider that uses a protective device must:

(1) document in the individual's case record any use of a protective device in accordance with the written service plan;

(2) ensure that a service provider has been trained in accordance with the written service plan and that the training is documented in the service provider's record; and

(3) ensure that a registered nurse, with input from the individual's service planning team, and other professional personnel, at least annually, and as the individual's needs change:

(A) evaluates and documents in the individual's case record the effects of the protective device on the individual's health and welfare;

(B) reviews the use of a protective device to determine its effectiveness and the need to continue the protective device; and

(C) revises the service plan based on subparagraphs (A) and (B) of this paragraph.

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter D, Additional Program Provider Provisions

§42.409 Restraints.

(a) A program provider providing licensed assisted living must comply with §92.41(p) of this title (relating to Standards for Type A and Type B Assisted Living Facilities).

(b) A program provider must ensure that a six-bed ICF/IID providing respite complies with §90.42(e)(4) of this title (relating to Standards for Facilities Serving Individuals with an Intellectual Disability or Related Conditions).

(c) A program provider providing licensed home health assisted living:

(1) must not use restraints for purposes of behavioral management, staff convenience, or discipline;

(2) may use a restraint only:

(A) if the use is authorized in writing by a physician and specifies:

(i) the circumstances under which the restraint may be used; and

(ii) the duration for which the restraint may be used; or

(B) if the use is necessary in a behavioral emergency to protect the individual or others from injury;

(3) except in a behavioral emergency, must ensure:

(A) that a service provider who uses a restraint has been trained in the use of the restraint:

(i) before using the restraint;
(ii) annually; and
(iii) as the individual's needs change; and

(B) that the training is documented in the service provider's record;

(4) must not use a restraint under any circumstance if it:

(A) obstructs the individual's airway, including a procedure that places anything in, on, or over the individual's mouth or nose;

(B) impairs the individual's breathing by putting pressure on the individual's torso;

(C) interferes with the individual's ability to communicate; or

(D) places the individual in a prone or supine position;

(5) must ensure that if a physical restraint is used in a behavioral emergency:

(A) it must be a restraint in which the individual's limbs are held close to the body to limit or prevent movement and that does not violate the provisions of paragraph (4) of this subsection;

(B) that as soon as possible but no later than one hour after the use of the restraint, the service provider notifies an RN of the restraint;

(C) that after the RN is notified of the use of the restraint, the service provider documents the RN's instructions to the service provider;

(D) that medical services are obtained for the individual as necessary;

(E) that with the individual's consent, the program provider makes an appointment with the individual's physician no later than the end of the first working day after the use of restraint and document in the individual's record that the appointment was made; or

(F) that if the individual refuses to see the physician, the program provider documents the refusal in the individual's record; and

(G) that as soon as possible but no later than 24 hours after the use of restraint, the program provider notifies one of the following persons, if there is such a person, that the individual has been restrained:

(i) the individual's LAR; or

(ii) a person actively involved in the individual's care, unless the release of this information would violate other law;

(6) that uses a restraint must document in an individual's case record:

(A) the use of the restraint;

(B) time and date;

(C) name of person administering the restraint;

(D) type of restraint and duration used; and

(E) if used in a behavioral emergency:

(i) events preceding the use of the restraint;

(ii) actions taken after the restraint; and

(iii) types of intervention attempted before the use of the restraint; and

(7) in order to decrease the frequency of the use of restraint, and to minimize the risk of harm to an individual, must ensure that a service provider is aware of and adheres to the findings of the nursing assessment required in §42.212(c)(2) of this chapter (relating to Process for Enrollment of an Individual) or in §42.223(b)(1) of this chapter (relating to Periodic Review and Update of IPC and IPP) for each individual.

Chapter 42, Deaf Blind with Multiple Disabilities (DBMD) Program
Subchapter F, Service Descriptions and Requirements
Division 2, Minor Home Modifications
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§42.615. Specifications for a Minor Home Modification.

(a) If DADS authorizes payment for specifications of a minor home modification in accordance with §42.614 of this division (relating to Requesting Authorization to Purchase a Minor Home Modification that Costs $1,000 or More), a program provider must:

(1) obtain the specifications from a person who has experience in constructing home modifications;

(2) ensure that the specifications:

(A) include a complete description of the minor home modification and any associated installations identified in the specifications;

(B) include a drawing or picture of both the existing room, structure, or other area and the proposed modification made to scale; and

(C) comply with the Texas Accessibility Standards promulgated by the Texas Department of Licensing and Regulation unless:

(i) the program provider determines that it is not structurally feasible to do so and documents, in writing, the basis for its determination; or

(ii) the individual or LAR requests, in writing, that the specifications not be in compliance with the Texas Accessibility Standards; and

(D) ensure the Specifications for Minor Home Modifications form is completed as described in the *DBMD Program Manual*.

(b) The program provider must obtain an invoice from the person who develops the specifications substantiating the cost of the specifications does not exceed $200 ~~$250~~.

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§42.620. Individual's Satisfaction with Minor Home Modification.

(a) A program provider must ensure that a service provider involved in purchasing the minor home modification for the individual:

(1) contacts the individual by phone or during an in-home visit within seven business days after completion of the inspection as described in §42.618 of this division (relating to Inspection of a Minor Home Modification) to determine whether the individual or LAR is satisfied with the minor home modification; and

(2) documents the result of the contact on DADS Documentation of Completion of Purchase form as described in the *DBMD Program Manual*.

(b) If the individual or LAR is not satisfied with the minor home modification, the program provider must process the individual's or LAR's dissatisfaction as a complaint in accordance with §49.309 ~~§42.406~~ of this title ~~chapter~~ (relating to Complaint Process ~~Quality~~

~~Assurance~~).

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Division 3, Requirements for Other DBMD Program Services
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§42.625. Employment Services.

(a) ~~General.~~ A program provider must ensure that a service provider of employment assistance and a service provider of ~~or~~ supported employment~~:~~
~~(1) is not the employer of the individual receiving the service or an employee of the individual's employer; and~~
~~(2)~~ meet the qualifications described in §42.402(g) of this chapter (relating to Staff Qualifications) ~~has at least one year of experience working with individuals with developmental disabilities~~.

(b) ~~Employment assistance.~~ Before including employment assistance on an individual's IPC, a program provider must ensure and maintain documentation in the individual's record that employment assistance is not available to the individual under a program funded under §110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

(c) ~~(1)~~ The program provider must ensure that ~~the~~ employment assistance:

(1) consists of a service provider performing the following activities:
(A) identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;
(B) locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements;
(C) contacting a prospective employer on behalf of an individual and negotiating the individual's employment;
(D) transporting the individual to help the individual locate paid employment in the community; and
(E) participating in service planning team meetings;

(2) is provided in accordance with the individual's IPC and with Appendix C of the DBMD waiver application approved by CMS and found at www.dads.state.tx.us;
~~service provider:~~
~~A) assists an individual, with the participation of the LAR, to identify:~~
~~(i) the individual's employment preferences;~~
~~(ii) the individual's job skills;~~
~~(iii) the individual's requirements for the work setting and work conditions;~~
~~(iv) the individual's network of natural supports, including job leads and contacts;~~
~~(v) assistive technology and other accommodations beneficial to the individual's career goals;~~
~~(vi) prospective employers that may offer employment opportunities compatible with the individual's identified preferences, skills, and requirements; and~~

~~(vii) transportation options; and~~
~~(B) facilitates the individual's employment by contacting prospective employers and negotiating the individual's employment.~~
~~Before including employment assistance on an individual's IPC, a program provider must ensure that similar services are not available to the individual through a program funded under §110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 USC §1401 et seq.).~~

(3) ~~A program provider must ensure employment assistance~~ is not provided to an individual with the individual present at the same time that one of the following DBMD Program services is provided:

(A) day habilitation;
(B) residential habilitation; ~~or~~
(C) supported employment~~.~~; or
(D) respite; and

(4) does not include using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses such as:

(A) paying an employer:

(i) to encourage the employer to hire an individual; or

(ii) for supervision, training, support and adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(B) paying the individual:

(i) as an incentive to participate in employment assistance activities; or

(2) for expenses associated with the start-up costs or operating expenses of an individual's business.

~~(4) A program provider may bill DADS for employment assistance only for the following activities:~~
~~(A) face-to-face or telephone contact with an individual or LAR concerning activities described in paragraph (1)(A) and (B) of this subsection;~~
~~(B) face-to-face or telephone contact with prospective employers concerning employment opportunities compatible with the individual's identified preferences, skills, and requirements;~~
~~(C) participation in service planning team meetings; and~~
~~(D) transporting an individual to and from potential work sites.~~

(d) Before including supported employment on an individual's IPC, a program provider must ensure and maintain documentation in the individual's record that supported employment is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

~~(c) Supported employment.~~

(e) ~~(1)~~ A program provider must ensure that ~~the~~ supported employment ~~service provider~~:

(1) consists of a service provider performing the following activities:

(A) employment adaptations, supervision, and training related to an individual's disability;

(B) transporting the individual to support the individual to be self-employed, work from home, or perform in a work setting; and

(C) participating in service planning team meetings;

(2) is provided in accordance with the individual's IPC and with Appendix C of the DBMD waiver application approved by CMS and found at www.dads.state.tx.us;

~~(A) provides ongoing individualized supports needed by an individual to sustain paid work in an integrated work setting;~~

~~(B) ensures employment is provided to an individual in a setting other than the individual's place of residence;~~

~~(C) does not perform supervisory activities rendered as a normal part of the business setting;~~

~~(D) does not provide supports to an individual who does not require such supports to continue employment;~~

~~(E) ensures the individual has access to transportation necessary for the individual's participation in supported employment;~~

~~(F) provides ongoing supervision and monitoring of the individual's satisfaction and performance on the job; and~~

(3) is not provided ~~(G) does not provide supported employment~~ to ~~the~~ an individual with the individual present at the same time that one of the following DBMD Program services is provided:

(i) day habilitation;

(ii) residential habilitation;

(iii) employment assistance; or

(iv) respite~~.~~; and

(4) does not include:

(A) sheltered work or other similar types of vocational services furnished in specialized facilities; or

(B) using Medicaid funds paid by DADS to the program provider for incentive payments, subsidies, or unrelated vocational training expenses such as:

(i) paying an employer:

(I) to encourage the employer to hire an individual; or

(II) for supervision, training, support and adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(ii) paying the individual:

(I) as an incentive to participate in supported employment activities; or

(II) for expenses associated with the start-up costs or operating expenses of an individual’s business;

~~Before including supported employment on an individual's IPC, a program provider must ensure that similar services are not available to the individual through a program funded under §110 of~~

~~the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 USC §1401 et seq.).~~
~~(3) DADS does not authorize payment for training that is not directly related to an individual's supported employment program.~~
~~(4) A program provider may bill DADS for supported employment only for the following activities:~~
~~(A) face-to-face or telephone contact with an individual at the individual's work site to provide training, support, and intervention necessary to sustain the individual's employment;~~
~~(B) face-to-face or telephone contact with an individual's LAR to sustain the individual's employment;~~
~~(C) face-to-face or telephone contact with an individual's employment supervisor as necessary to sustain the individual's employment;~~
~~(D) participation in service planning team meetings; and~~
~~(E) transporting an individual to and from the work site.~~

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§**42.626. Habilitation.**

(a) General.

(1) A program provider may deliver habilitation as:

(A) day habilitation; or

(B) residential habilitation.

(2) A program provider may bill for time spent by a day habilitation or residential habilitation service provider:

(A) in direct contact with an individual;

(B) participating as a member of an individual's service planning team; or

(C) performing tasks delegated by a physician or RN ~~registered nurse~~.

(3) A program provider must not bill for time spent by a day habilitation or residential habilitation service provider:

(A) in administrative meetings;

(B) in inservice or general training;

(C) processing paperwork; or

(D) traveling to or from an individual's home, except when the service provider is transporting the individual.

(4) The documentation required by §42.405(a)(7) of this chapter, (relating to Record Keeping), must include the individual's progress or lack of progress in achieving ~~A program provider must document~~ the following outcomes for day or residential habilitation ~~in the individual's record~~:

(A) the ability to ~~individual~~ effectively communicate the individual's ~~communicates~~

wants and needs to a day or residential habilitation service provider;

(B) the ability to ~~individual~~ actively participate ~~participates~~ in activities of daily living to the extent of the individual's ability;

(C) the ~~individual's~~ ability to implement the individual's choices ~~are implemented~~;

(D) the ability ~~individual is able~~ to access and participate in community activities; and

(E) the ability ~~individual is able~~ to move safely and efficiently within the day habilitation or residential habilitation setting.

~~(5) If requested by DADS, a program provider must be able to demonstrate the outcomes in paragraph (4)(A)-(E) of this subsection.~~

(b) Day habilitation. A program provider must ensure:

(1) day habilitation:

(A) is provided in a non-residential setting separate from the individual's own or family home or the residence in which the individual receives licensed assisted living or licensed home health assisted living that:

(i) is accessible to and usable by the individual;

(ii) is maintained in good repair;

(iii) has at least two means of egress; and

(iv) is in continuous compliance with applicable local building codes and ordinances and applicable state and federal laws, rules, and regulations;

(B) reinforces:

(i) therapeutic outcomes identified ~~targeted~~ by other DBMD Program services; and

(ii) for an individual eligible for public education services, education goals in the Individualized Education Program (IEP) and services provided by the school district;

(C) includes transportation necessary for the individual's participation in day habilitation activities;

(D) is not provided to the individual at the same time that one of the following DBMD Program services is provided:

(i) employment assistance with the individual present;

(ii) supported employment with the individual present;

(iii) residential habilitation; or

(iv) respite;

(2) a day habilitation service provider works with one individual at a time unless the individual's service planning team documents on the IPP that the individual's needs can be

met with a day habilitation service provider to individual ratio of one-to-two or one-to-three;

(3) that for a service provider to individual ratio higher than one-to-three, that the IPP includes a recommendation from the service planning team ~~recommendation on the IPP for a day habilitation service provider to individual ratio higher than one-to-three is supported by~~ and supporting documentation of the individual's ability to integrate and meaningfully participate in an environment with a ~~higher~~ ratio higher than one-to-three;

(4) a day habilitation service provider:

(A) develops and implements a written emergency response plan that describes the actions the day habilitation service provider will take in the event of an emergency such as a fire or other man-made or natural disaster at a day habilitation site including evacuation or sheltering-in-place of the individual, as appropriate;

(B) takes into account the needs and abilities of the individual in developing the emergency response plan;

(C) requires its staff members to demonstrate competency in implementation of the emergency response plan at the time job duties are assumed and annually thereafter;

(D) reviews the emergency response plan at least annually and, if necessary, revises the plan;

(E) maintains a copy of the current emergency response plan in a location that is easily accessible by all staff at the day habilitation site;

(F) conducts a fire drill at least once every 90 calendar days; and

(G) documents that requirements in subparagraphs (C)-(F) of this paragraph are met.

(c) Residential habilitation.

(1) A program provider must ensure:

(A) residential habilitation:

(i) is provided:

(I) in the individual's own or family home; or

(II) in a setting outside the individual's own or family home appropriate for the type of residential habilitation activities described in the individual's IPP;

(ii) for an individual under 18 years of age, is not provided by the individual's parent or managing conservator;

(iii) ~~may include~~ includes as identified by the service planning team as documented on the IPP:

(I) transportation necessary for the individual to participate in community activities or assistance in securing such transportation;

(II) assistance with ambulation and mobility;

(III) reinforcement of behavioral support or therapy activities;

(IV) assistance with medications and the performance of tasks delegated by an RN in accordance with state law;

(V) supervision of the individual's safety and security;

(VI) assistance with acquisition, retention, or improvement in skills related to activities of daily living, including:

(-a-) personal grooming and cleanliness;

(-b-) bed making and household chores; and

(-c-) preparation and consumption of food;

(VII) use of natural supports and typical community services; and

(VIII) social interaction and participation in leisure activities;

(iv) is not provided to the individual at the same time that one of the following DBMD Program services is provided:

(I) employment assistance with the individual present;

(II) supported employment with the individual present;

(III) day habilitation;

(IV) respite; or

(V) licensed assisted living or licensed home health assisted living; ~~and~~

(B) a residential habilitation service provider works with no more than one individual at a time; and ~~.~~

(C) compliance with §42.407 of this chapter (relating to Service Backup Plans);

(2) DADS does not reimburse a program provider for:

(A) the routine care and supervision that a family member is legally obligated to provide;

(B) activities or supervision for which a payment is made by a source other than Medicaid;

(C) room and board; or

(D) any service that is not provided in accordance with this chapter and the *DBMD Program Manual*.

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§42.628. Nursing.

(a) A program provider must ensure that a RN ~~registered nurse (RN)~~ or ~~licensed vocational nurse (~~LVN~~)~~ provides nursing in accordance with rules at 22 TAC Part 11 (relating to Texas Board of Nursing).

(b) If an individual requires specialized nursing, a program provider's RN ~~registered nurse~~ must complete the Specialized Nursing Certification form as described in the *DBMD Program Manual* and obtain DADS authorization for specialized nursing prior to providing care.

(1) The RN must indicate on the form that a physician has determined the individual requires:

(A) use of a ventilator at least six hours per day; or

(B) tracheostomy care at least once per day to include cleansing, dressing, and suctioning of the tracheostomy.

(2) The program provider must:

(A) ensure the case manager submits the completed form ~~is submitted~~ to DADS with the IPC; and

(B) keep the original completed form in the individual's record.

(c) If DADS approves specialized nursing for an individual, the program provider must ensure that all nursing services provided to the individual after the date of DADS approval are billed as specialized nursing.

(d) A program provider must ensure compliance with§42.407 of this chapter (relating to Service Backup Plans).

(e) ~~(d)~~ A program provider may bill DADS at the RN, LVN, specialized RN, or specialized LVN rates only for the following nursing activities:

(1) interacting face-to-face or by telephone with an individual to provide professional or vocational nursing for which there is a documented or immediate medical necessity, including:

(A) preparing and administering medication or treatment ordered by a physician, podiatrist, or dentist;

(B) assisting or observing self-administration of medication; and

(C) assessing an individual's health status;

(2) interacting face-to-face or by telephone with a person, except a service provider of nursing, case management, or a therapy, regarding the health status of an individual;

(3) performing health care procedures ordered or prescribed by a physician or medical practitioner and required by standards of professional practice or law to be performed by licensed nursing personnel;

(4) delegating, verifying the competency of, and supervising an unlicensed person in the performance of a task delegated in accordance with rules at 22 TAC Part 11;

(5) providing training to a service provider that is specific to an individual;

(6) providing training or orientation to an individual, LAR, family member, or service provider concerning an adaptive aid or minor home modification; and

(7) participating in service planning team meetings.

(f) ~~(e)~~ A program provider may bill DADS at a nursing rate for a nurse's performance of delegated tasks if:

(1) a service provider to whom a nurse has delegated the performance of delegated tasks is unavailable to perform those tasks;

(2) a backup service provider is unavailable; and

(3) the individual's health and welfare would be endangered if those tasks are not delivered.

(g) ~~(f)~~ If a program provider bills DADS as described in subsection (f) ~~(e)~~ of this section, the program provider:

(1) must not bill for more than 10 hours of such services per IPC period;

(2) must document in the individual's record:

(A) efforts made to find a service provider who is not an RN or LVN to perform the delegated tasks; and

(B) reasons the failure to provide the delegated tasks would endanger the individual's health and welfare.

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§**42.630. Residential Services.**

(a) General.

(1) A program provider may provide residential services as:

(A) licensed assisted living, either 18 hour or 24 hour; or

(B) licensed home health assisted living, either 18 hour or 24 hour.

(2) A program provider must:

(A) provide personal assistance with activities of daily living;

(B) provide assistance with housekeeping;

(C) provide therapeutic social and recreational activities;

(D) provide on-site response staff to meet scheduled or unpredictable needs;

(E) provide supervision of an individual's safety and security; and

(F) provide, or make arrangements for, transportation other than medical transportation.

(3) A program provider must not provide either licensed assisted living or licensed home health assisted living to the individual at the same time that one of the following DBMD Program services is provided:

(A) respite;

(B) residential habilitation; or

(C) chore services.

(4) A program provider must ensure that an individual transitioning from institutional services to either licensed assisted living or licensed home health assisted living is not receiving TAS.

(5) DADS does not reimburse a program provider for 24-hour skilled nursing care provided to an individual receiving residential services.

(6) If an individual is absent from the residence for six or more hours in a day, a ~~A~~ program provider may ~~must~~ bill for 18-hour licensed assisted living or 18-hour licensed home health assisted living, and must not bill for 24-hour licensed assisted living or 24-hour licensed

home health assisted living.
~~for those days an individual is absent from the residence for six or more hours participating in school, work, or volunteer activities.~~

(7) If an individual's IPC includes day habilitation, the program provider may ~~must~~ bill for 18-hour licensed assisted living or 18-hour licensed home health assisted living for those days in ~~on~~ which the individual participates in day habilitation, but must not bill for 24-hour licensed assisted living or 24-hour licensed home health assisted living.

(8) A program provider must maintain documentation of the daily census using the Daily Census Documentation form described in the *DBMD Program Manual* or a form developed by the program provider which captures the information addressed on the Daily Census Documentation form.

(9) A program provider must notify DADS in writing of an individual's death within 24 hours after learning of the death.

(10) The program provider must have and implement written policies ~~polices~~ and procedures concerning room and board payment, to include:

(A) how the program provider determines the amount of room and board based on the costs of maintaining the residence;

(B) due date;

(C) credit balances;

(D) written notice of late payment to include late fees;

(E) return check charges;

(F) provision of receipt at time payment is made; and

(G) proportional refund when individual moves from the residence.

(11) ~~(10)~~ The program provider must maintain a room and board ledger in accordance with generally accepted accounting principles.

(12) If a program provider provides an item or service at the request of the individual or LAR that is not a reimbursable item, the program provider may charge the individual or LAR for the items or service but must not bill DADS.

(13) A program provider must not charge a pet deposit to an individual or LAR for a service animal, including a guide dog, signal dog, or other animal individually trained to provide assistance to the individual.

(14) The documentation required by §42.405(a)(7) of this chapter, (relating to Record Keeping), must include the individual's progress or lack of progress in achieving ~~A program provider must document~~ the following outcomes for residential services ~~in the individual's record~~:

(A) the ability to ~~individual~~ effectively communicate the individual's ~~communicates~~ wants and needs to a residential services service provider;

(B) the ability to ~~individual~~ actively participate ~~participates~~ in activities of daily living to the extent of the individual's ability;

(C) the ~~individual's~~ ability to implement the individual's choices ~~are implemented~~;

(D) the ability ~~individual is able~~ to access and participate in community activities; and

(E) the ability ~~individual is able~~ to move safely and efficiently within home and community settings.

~~(15) If requested by DADS, a program provider must be able to demonstrate the outcomes described in paragraph (14)(A)-(E) of this section.~~

(b) Licensed assisted living. A program provider must:

~~(1) must comply with applicable provisions of Chapter 92 of this title (relating to Licensing Standards for Assisted Living Facilities);~~

(1) ~~(2) must~~ serve no more than six individuals in a single residence;

(2) have a working carbon monoxide detector installed in each individual's bedroom;

(3) ~~must~~ not bill DADS for the cost of a minor home modification; and

(4) ~~must~~ notify the DBMD program specialist in writing of a fire, accident, or natural disaster within 24 hours after becoming aware of the occurrence.

(c) Licensed home health assisted living.

(1) A program provider ~~:~~

~~(A) must comply with applicable provisions of Chapter 97 of this title (relating to Licensing Standards for Home and Community Support Services Agencies);~~

~~(B)~~ must serve no more than three individuals in a single residence (e.g., an apartment, house, or duplex). ~~; and~~

(2) A program provider must conduct and document the results of a home inspection to determine compliance with the requirements in paragraph (4) of this subsection for a residence:

(A) before providing services and then annually for a residence not used to provide licensed home health assisted living services before Sept 1, 2014; or

(B) before Sept 30, 2014 and then annually for a residence used to provide licensed home health assisted living before Sept 1, 2014.

(3) A program provider must ensure correction of any noncompliance found during the home inspection and document the correction.

(4) ~~(C)~~ A residence in which licensed home health assisted living is provided must ~~ensure~~

~~the residence of an individual~~:

(A) ~~(i) is~~ be accessible to and usable by the individuals receiving services in the residence ~~individual~~;

(B) ~~(ii) is maintained~~ be maintained in good repair; ~~and~~

(C) ~~(iii) has~~ have at least two means of egress from:

(i) ~~(I)~~ the living areas; and

(ii) ~~(II)~~ the individual's bedroom;

(D) ~~(iv) has~~ have working smoke alarms installed ~~to detect smoke~~ in the kitchen, living areas, and the individual's bedroom; ~~and~~

(E) ~~(v) has~~ have a universal, fully-charged, and unexpired fire extinguisher easily accessible:

(i) ~~(I)~~ from the kitchen;

(ii) ~~(II)~~ from the laundry area;

(iii) ~~(III)~~ from the vicinity of a hot water heater or furnace;

(iv) ~~(IV)~~ from each bedroom area; and

(v) ~~(V)~~ on each floor of a multi-level residence; ~~and~~

(F) ~~(vi) has~~ have a first aid kit that complies with American Red Cross recommendations ~~and is checked at least annually to ensure~~ with contents that are not out-of-date; ~~and~~

(G) ~~(vii) the~~ have water temperature that does not exceed 110 degrees Fahrenheit ~~of water~~ from faucets used by an individual who cannot regulate water temperature ~~does not exceed 110 degrees Fahrenheit;~~ .

(H) have a locked container that can be used to store the medications for the individual as required by paragraph (5) of this subsection;

(I) have a place to store flammable or poisonous substances in a manner that makes them inaccessible to the individuals; and

(J) have a working carbon monoxide detector installed in each individual's bedroom.

(5) ~~(2)~~ The program provider must ensure:

(A) an individual's prescribed medication is stored in a locked container and in the original container labeled with:

(i) individual's name;

(ii) date dispensed;

(iii) instructions;

(iv) name of medication with dosage; and

(v) physician's name;

(B) a medication requiring refrigeration is kept separate from food in a clearly labeled, designated locked container;

(C) a medication that is no longer needed by the individual or that is past its expiration date is disposed of according to federal and state laws and regulations;

(D) a medication prescribed for one individual is not given to another individual; and

(E) an individual takes prescribed medications according to the physician's instructions and over-the-counter medications according to the package directions.

(6) ~~(3)~~ A program provider must:

(A) develop and implement a written emergency response plan for the residence that describes the actions the program provider will take in the event of an emergency, such as a fire or other man-made or natural disaster, including evacuation or sheltering-in-place of the individual, as appropriate;

(B) ensure that:

(i) the emergency response plan takes into account the abilities of the individual to follow the plan;

(ii) the individual receives instruction concerning the emergency response plan:

(I) within 48 hours after the individual moves into the residence and annually thereafter; and

(II) if the individual's ability to follow the emergency response plan changes;

(iii) the individual's service providers demonstrate competence ~~competency~~ in implementing ~~implementation of~~ the emergency response plan at the time job duties are assumed and annually thereafter;

(iv) the emergency response plan is reviewed and revised by the program provider when necessary and at least annually; and

(v) a copy of the current emergency response plan is:

(I) maintained in the residence; and

(II) accessible to service providers.

(7) ~~(4)~~ The program provider must ensure ~~an individual participates in a fire drill~~:

(A) an individual successfully participates in a fire drill within 48 hours after the individual moves into the residence;

(B) all individuals in the residence successfully participate in a fire drill at least every 90 calendar days ~~thereafter~~, with at least two drills per year conducted when at least one individual is sleeping ~~during the individual's normal sleep hours~~; and

(C) an individual successfully participates in a fire drill within 48 hours after a change in ~~if~~ the individual's condition occurs that may negatively affect the individual's ability to participate in a fire drill ~~changes~~.

(8) ~~(5)~~ The program provider must ensure:

(A) the residence has furnishings that are safe for the individual in all common areas;

(B) a bedroom in the residence:

(i) has at least:

(I) 80 square feet of floor space for a single occupancy room; and

(II) 60 square feet of floor space per individual in a double occupancy room;

(ii) was built as a bedroom when the residence was built, or was remodeled under a permit that meets local building codes;

(iii) is finished with walls or partitions of standard construction that go from floor to ceiling;

(iv) is adequately ventilated and lighted;

(v) has at least one window that will open freely and remain open from the inside without special tools;

(vi) has no more than two beds in any room;

(vii) has adequate drawer and closet space; and

(viii) provides comfortable sleeping arrangements for the individual;

(C) the residence has a common telephone or other communication system usable by the individual and for which:

(i) an individual has an opportunity to have input on residence procedures concerning:

(I) time limits on calls; and

(II) privacy during an individual's use of the phone; and

(ii) the program provider does not charge an individual for local calls; and

(D) bathrooms have adequate supplies of towels, washcloths, soap, and toilet tissue at all times. ~~; and~~

~~(E) flammable or poisonous substances are stored in a manner to make them inaccessible to an individual.~~

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Subchapter F, Service Descriptions and Requirements
Division 3, Requirements for Other DBMD Program Services
35 TexReg 5042 pub date 6/11/10 eff date 6/15/10

§**42.631. Respite.**

(a) General.

(1) A program provider may deliver respite as:

(A) in-home respite; or

(B) out-of-home respite.

(2) A program provider must not:

(A) bill DADS for more than 30 calendar days or 720 hours of respite per IPC period;

(B) provide respite to an individual receiving licensed assisted living or licensed home health assisted living;

(C) permit an individual's spouse or a paid caregiver of residential habilitation with whom the individual lives to provide respite; or

(D) provide respite to an individual at the same time that one of the following DBMD Program services is provided to the individual:

(i) employment assistance with the individual present;
(ii) ~~(i)~~ supported employment with the individual present;
(iii) ~~(ii)~~ day habilitation; or
(iv) ~~(iii)~~ residential habilitation.

(3) A program provider must ensure that a respite service provider meets the qualifications described in §42.402(i) ~~§42.402(g)~~ of this chapter (relating to Staff Qualifications) and the training requirements described in §42.403 of this chapter (relating to Training).

(b) In-home respite. A program provider must ensure that in-home respite is provided in the private residence of:

(1) the individual;
(2) the individual's family; or
(3) a respite service provider.

(c) Out-of-home respite.

(1) A program provider must ensure that out-of-home respite is provided in a location listed in paragraph (2) of this subsection acceptable to the individual or LAR that:

(A) is an accessible, safe, and comfortable environment for the individual; and

(B) promotes the individual's health and welfare.

(2) A program provider must provide out-of-home respite in one of the following:

(A) an ICF/IID with a certified capacity of six or less persons ~~ICF/MR~~;

(B) an assisted living facility (ALF) with a licensed capacity of six or less persons; or

(C) an outdoor camp accredited by the American Camping Association.

(3) A program provider may provide out-of-home respite in a residence in which licensed assisted living or licensed home health assisted living is provided if:

(A) a vacancy exists in the residence;
(B) the individual or LAR approves; and
(C) the service planning team for each individual receiving services in that residence makes a determination that the respite visit will cause no threat to the health, safety and welfare, or rights and needs of that individual.