Policy Title: Children's Waiver Home and Community-Based Services (HCBS) Service Definitions and Necessity Criteria Policy

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Applicable to: Providers of Home and Community-Based Services (HCBS) under the 1915(c) Children's Waiver, Health Homes Serving Children, Care Management Agencies, Children and Youth Evaluation Service (C-YES), and Medicaid Managed Care (MMC) Plans, including HIV Special Needs Plans (HIV SNPs).

This policy consolidates and clarifies existing requirements and supersedes other guidance and webinar presentations issued prior to this policy. This policy contains service definitions which have been effective since the inception of the Children's Waiver in 2019 and reflects the provider qualifications that are currently in effect. Adherence to the standards outlined in this policy is the responsibility of the HCBS provider, Health Homes Serving Children, Care Management Agencies, Children and Youth Evaluation Service (C-YES), and Medicaid Managed Care (MMC) Plans, including HIV Special Needs Plans (HIV SNPs).

I. Purpose

This policy is designed to ensure that every HCBS participant receives individualized care that is aligned with their unique needs, preferences, and goals, thereby fostering their holistic well-being, and empowering their families/caregivers. All services must be provided in accordance with the definitions and requirements outlined in this policy.

HCBS are community-based services to prevent the need for institutional care such as psychiatric hospitalization, residential treatment, or nursing home admission, or to assist the participant to return to their home and community after discharge from an institutional level of care. To be eligible for HCBS, participants must have a medical condition, developmental disability, and/or serious mental health disorder that is impacting their daily functioning and that places them at imminent risk of hospitalization or institutionalization, or results in the need for supports to return safely home and to their community after discharge from an institutional level of care, as outlined in the Children's Home and Community Based Services (HCBS) Waiver Enrollment Policy. Participants must be under 21 years of age and enrolled in Medicaid or eligible for Medicaid (either through Community budgeting or Family of One budgeting) to be enrolled in the Children's Waiver.

All services provided must be based on the participant's assessed needs and goals and must be necessary to support the participant remaining in the home and community. The frequency, scope, and duration (F/S/D) of services must be tied to the identified

needs and goals in the Service Plan and be supported by documentation in the participant's case record. The amount and number of services must take into consideration the participant's age, development, and condition, along with the participant's other appointments and activities. If changes occur that result in increased or decreased need for services, providers should adjust service provision as necessary, document the rationale for changes in services or service levels, and obtain authorization when necessary.

It is the responsibility of the Health Home Care Manager (HHCM) or Children and Youth Evaluation Services (C-YES) to determine initial eligibility for Children's HCBS and annually thereafter. It is also the responsibility of the HHCM/C-YES to educate the participant/family on Children's Waiver requirements and limitations including the requirement to explore other available resources prior to pursuing Children's Waiver enrollment. Participants found eligible for the Children's Waiver can choose to enroll and select which designated agencies they'd like to receive services from. The HHCM/C-YES will generate and issue HCBS referrals as appropriate, develop and update a Plan of Care (POC) and communicate with care team members, inclusive of the HCBS provider(s), to share updates and information relevant to the participant's participation in HCBS.

HCBS Providers must verify that each service is appropriate to meet the needs and goals of the participant and can be provided. The HHCM/C-YES and HCBS providers must have on-going communication and collaboration regarding the participant's enrollment, service progress, discharge from services, continued Waiver eligibility, their Plan of Care/Service Plan, and disenrollment from the Waiver.

II. Contents

III. Requirements Applicable to All Services

The requirements contained in this section are applicable to all Children's Waiver HCBS. Additional details regarding the required components of each service, the modalities and settings appropriate for the service, provider agency and staff qualifications, service necessity requirements, continued stay and discharge criteria, and utilization expectations can be found in the service-specific sections below.

A. Definition

HCBS are community-based services to prevent the need for institutional care such as psychiatric hospitalization, residential treatment, or nursing home admission, or to assist the participant to return to their home and community after discharge from an institutional level of care. To be eligible for Children's Waiver HCBS, participants must have a medical condition, developmental disability, and/or serious mental health disorder that impacts their daily functioning and that places them at imminent risk of hospitalization or institutionalization, or results in the need for supports to return safely home and to their community after discharge from an institutional level of care. All services must be provided based on the participant's assessed needs and goals and must be necessary to assist a waiver participant to avoid institutionalization and function in the community.

This policy provides definitions for each HCBS in each of the service-specific sections below.

B. Service Components

This policy contains the service components of each HCBS in each of the service-specific sections below.

C. Modality

HCBS cannot be provided via telehealth. Additional details on staffing ratios and group services are provided in each of the service-specific sections below.

D. Setting

Services are required to be offered in the least restrictive setting for the desired outcomes, including the most integrated home or other community-based settings where the participant lives, works, engages in services, and/or socializes. It also includes settings in the family and caregiver network. Family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) will exhibit

characteristics and qualities most often articulated by the individual participant and family/caregiver as key determinants of independence and community integration.

HCBS cannot be provided in residential or institutional settings providing comprehensive care, including, but not limited to hospitals, residential treatment facilities, skilled nursing facilities, and other institutional settings where a participant resides. Furthermore, individuals residing in certain residential or institutional settings are not eligible to receive HCBS when HCBS would be considered duplicative of services provided in the residential or institutional setting in which the member resides, regardless of where the HCBS is delivered. However, some individuals residing in restricted settings may be eligible for HCBS, if the HCBS is not duplicative of services provided in the residential setting and if they are provided at another allowable location. Refer to Appendix A of this document, the HCBS Settings Final Rule Compliance Policy, and the HCBS Manual for additional information on HCBS setting restrictions.

Unless the service definition allows for services to be provided to groups of participants, HCBS must be provided to individual participants, based upon their individualized assessed needs and goals.

Additional information on disenrollment of participants residing in ineligible settings can be found in the Children's HCBS Eligibility and Enrollment Policy.

Additional details on settings requirements are provided in each of the service-specific sections below.

E. Limitations/Exclusions and Utilization

Waiver services complement and/or supplement the services that are available through the Medicaid State plan and other federal, state and local public programs, as well as the supports that families and communities provide to individuals,[1] and when applicable, third-party insurance coverage. HCBS cannot duplicate or replace services otherwise available to the participant, including services available through the Medicaid State Plan, Section 110 of the Rehabilitation Act of 1973 (Rehabilitation Act), the Individuals with Disabilities Education Act (IDEA), private insurance, or Medicare.[2] HCBS are not an appropriate substitute for medically necessary care covered under the state plan such as Early Intervention (EI), Applied Behavior Analysis (ABA) therapy, mental health

[1] Instructions Technical Guide and Review Criteria

[2] Centers for Medicare and Medicaid Services §1915(c) Home and Community-Based Waiver Instructions, Technical Guide and Review Criteria, p. 136, “the waiver may provide that a service only will be furnished when it is not available through the state plan.”

assessment and treatment, physical therapy, occupational therapy, speech therapy, personal care assistance, and private duty nursing.

Rehabilitation services, which are services intended to restore and improve skills and function that have been lost or impaired, are available as State Plan services. For example, Psychosocial Rehabilitation is covered for participants whose skill performance has been impacted due to behavioral health conditions. Habilitation Services available under the Children's Waiver, which are intended to help individuals with intellectual/developmental disabilities acquire, retain, and improve skills are not appropriate substitutes for rehabilitation services authorized under the State Plan.

Children's HCBS is not billable when provided while another billable Medicaid service is provided, except in limited circumstances. Services that are substantively equivalent but cover care gaps because the procedures or form of that service is different in parameters such as time, quantity or acuity of service may be an exception. This is only permissible when HCBS is not duplicative in any way of the other services being provided. For example, it is not appropriate for Respite to be provided while the participant is receiving another service that includes general supervision of the child in the caregiver's absence, such as applied behavior analysis, or personal care assistance. It is not appropriate for habilitation services to be provided/billed at the same time that a child is receiving some form of medically necessary therapy. However, it may be appropriate for a child to receive palliative care while also receiving private duty nursing services. HCBS providers must coordinate with the care manager and family to ensure services are coordinated to avoid duplication and ensure appropriate scheduling of services. When it is necessary for the participant to receive more than one service simultaneously, the rationale must be documented in the member's record or plan of care, explaining the need for a combination of services and how the services complement each other.

When appropriate and necessary during HCBS delivery, direct care workers may attend to the participant's medical and non-medical needs and other ADLs which would ordinarily be performed by a caregiver or family member. However, unlicensed direct care workers are not permitted to utilize medical equipment, administer medications, or utilize medical devices without appropriate training by a licensed professional. If requested by the family, determined appropriate by a clinician, and approved by the designated HCBS agency, an appropriately licensed professional such as a registered nurse, physical therapist, or occupational therapist may provide training to the direct care staff member to provide limited medical supports that do not require licensure. Documentation of staff training must be maintained in the participant/staff record. All services must be provided in alignment with the service definition.

Some HCBS allow for both an Individual and Group modality. Group and Individual billing for the same service cannot overlap.

Services cannot be provided during school hours to participants attending school.

Additionally, Children's HCBS is not a substitute for parenting, babysitting, childcare, or generalized supervision. HCBS must be provided in a professional capacity with a clearly defined need that exceeds general childcare needs. HCBS does not replace the role of the parent/caregiver in fostering skill development essential to typical child development.

Children's HCBS cannot duplicate or replace the role of the participant's care manager.

Additional details on limitations/exclusions and utilization are provided in each of the service-specific sections below.

The anticipated utilization ranges in each of the service-specific sections below are provided as a guideline to assist in developing the HCBS Service Plan and is not a guaranteed or appropriate for all HCBS participants. Frequency of services may be different for participants in school versus participants who have graduated/aged out of school settings and must take into consideration the participant's age, development, and condition, along with the participant's other appointments and activities.

F. Certification/Provider Qualifications

In addition to staff meeting the service-specific provider qualifications, staff must be able to safely and effectively serve the participant. It is the responsibility of the HHCM/C-YES to share adequate information about the participant's needs as part of the HCBS referral to allow the provider to determine if they can meet the participant's need(s) in alignment with the service definition and requirements. It's the responsibility of the designated agency to ensure that HCBS staff have adequate knowledge and skills to address the individual participant's needs (including but not limited to physical and/or medical needs such as positioning or technology) OR have made arrangements for an appropriately trained and knowledgeable individual to address the individual participant's needs (including but not limited to physical and/or medical needs such as medications or technology). Examples include arrangement of an approved Private Duty Nurse for a technology dependent participant while in a Respite setting.

Provider Agency Qualifications

Practitioners must operate in agencies that have been designated through the NYS Children's Provider Designation Review Team. This requires that agencies have appropriate license, certification, and/or approval in accordance with State designation requirements.

- Provider agencies and practitioners must adhere to all Medicaid requirements in this policy and in other applicable provider policies, manuals, regulations, and statutes.
- Provider agencies must adhere to cultural competency guidelines.

- Provider agencies must be knowledgeable and have experience in trauma-informed care and working with individuals from the cultural groups of those being served.
- The provider agency must ensure that staff receive Mandated Reporting training prior to service delivery.
- The provider agency must ensure that practitioners maintain the licensure necessary to provide services under their scope of practice under State law if applicable.
- The provider agency must ensure that any insurance required by the designating state agency is obtained and maintained.
- The provider agency must ensure that any safety precautions needed to protect the participant population served are taken as necessary and required by the designating State agency.

Additional information and application for Children's HCBS can be found on the Department of Health (DOH) website.

Each service has specific qualification requirements for staff delivering services. In addition, certain provider agency and supervisory requirements may apply for some services.

Individual Staff Qualifications:

Staff who provide direct care to participants under the age of 21 are required to have a Criminal History Record Check (CHRC) through DOH.

The provider agency is required to conduct a Staff Exclusion List (SEL) check through the NYS Justice Center for the Protection of People with Special Needs (Justice Center) for all staff that will have regular and substantial contact with individuals under the age of 21.

The provider agency is required to conduct a Statewide Central Register (SCR) Database check through OCFS for those employees that will have regular and substantial contact with participants, which includes but is not limited to HCBS providers. Additional information about background check requirements can be found in the HCBS Background Check Policy.

To ensure a Children's Waiver enrollee's autonomy, preserve Freedom of Choice and reduce the potential for conflicts of interest, staff providing Children's HCBS cannot be immediate family members, individuals that are legally or financially responsible for the HCBS-enrolled youth/child, or an individual residing in the same residence as the HCBS-enrolled child/youth.

HCBS provided by any of the following individuals to a Children's Waiver enrollee is not eligible for reimbursement:

- An immediate family member, which is defined as:
    - Parent (biological, adoptive, or in-law)/stepparent/foster parent
    - Grandparent or any variation (e.g., great grandparent, step-grandparent)
    - Child or sibling (biological, adoptive, or in-law)/stepsibling
    - Current or former spouse
- Any individual residing in/living in the home of the HCBS enrollee.
- An individual who is legally or financially responsible for the HCBS-enrolled child/youth which includes:
    - A Parent or Legal Guardian
    - Legally Responsible Individual (LRI)/ Legally Authorized Representative (An LRI is any person who has a duty under state law to care for another person and includes: (a) the parent (biological, adoptive, foster, or step) or guardian of a minor child or (b) a spouse of a waiver enrollee)
    - Individual who is financially responsible for the HCBS enrollee

Conflicts of interest are not limited to the list of individuals above and may exist in relationships beyond those included in this list. If a relationship with an individual, such as a distant relative or friend could affect the enrollee/family's freedom of choice or present a conflict of interest, then that individual should not provide HCBS to the enrollee. It is the responsibility of the Designated HCBS Provider to determine if a potential conflict of interest is present in a potential staffing relationship (due to family, social, personal, or other reasons) and make staffing decisions accordingly.

Additional details on provider requirements are found in each of the service-specific sections below.

G. Service Admission Requirements

HCBS may only be provided when the following criteria are met:

- The participant was found HCBS eligible by a Health Home Care Manager (HHCM), Children and Youth Evaluation Service (C-YES) assessor, or an allowed Office of Mental Health Single Point of Access through conducting the HCBS Eligibility Determination.
    - The HCBS Eligibility Determination is active within 365 days from being completed.
    - The Participant has active K-codes.
    - The participant is enrolled in care management either through HHCM or C-YES.
- The need for the service has been assessed, determined, and authorized in alignment with the service definition as part of the person-centered planning process.
- The service is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s) and outcome(s) to enhance the participant's ability to remain in the home/community.

- A referral for HCBS that outlines the assessed needs and goals of the participant and the requested service, has been made to a designated HCBS provider from a HHCM/C-YES.

When making a referral for HCBS, the care manager must explain the types of services recommended and provide the participant/family with the applicable HCBS Service Information Sheet. The care manager must document in the participant's record that this information was provided.

Additional details on service necessity requirements are provided in each of the service-specific sections below.

H. Service Necessity Documentation

Prior to any HCBS delivery, the HCBS provider must receive a referral from the participant's HH/C-YES care manager. It is the responsibility of the HCBS provider to evaluate the referral for appropriateness and confirm the participant's eligibility prior to delivery of any HCBS. After determining appropriateness, the HCBS provider can provide HCBS for the Initial Service Period. The Initial Service Period is the period of time after accepting an HCBS referral but prior to submitting an HCBS Authorization Request lasting up to 96 units/24 hours or 60 days (whichever comes first). The Initial Service Period begins on the first date of billable service for the participant and is service specific. The Initial Service Period is used to complete an intake assessment, to finalize service goals and objectives, and determine Frequency/Scope/Duration (F/S/D) for the service. If the service is needed beyond the Initial Service Period, an HCBS Authorization is needed.

The HCBS provider must maintain documentation that clearly substantiates the need for services to support the participant remaining in the home/community and must support the proposed frequency, scope, and duration of the service. The HCBS provider should work with the participant's other involved care professionals and the care manager to obtain documentation to support the proposed level of service provision and appropriateness for the type and amount of service being offered to meet the participant's identified need and goals. This may include assessments completed by the HCBS provider or a licensed professional, applicable evaluations conducted by a licensed practitioner, test results, diagnoses from licensed practitioners, school information, documentation of presenting problem(s), and/or demonstration of functional limitations. Documentation may vary by service and by participant but may include any intake evaluation/assessments completed by the provider, documentation from a licensed professional working with the participant indicating the need for services, and/or other evaluations outlining the participant's needs. Ongoing service progress notes should illustrate service necessity by outlining interventions utilized to meet the goals/objectives, responses from the participant/family, progress made towards goals, and ongoing communication with the care manager and other service providers.

Service utilization that exceeds the service limits (i.e., annual, monthly, daily, dollar amount) is expected to be rare, temporary, and must be necessary to prevent institutionalization and support the participant remaining in the home/community. As outlined in the Documentation Policy, service authorization requests in excess of the service limits must be justified by documentation from a third-party involved in the member's care demonstrating this need. Third-party entities are entities external to the HCBS provider, the care management agency, and the Health Home, or if this documentation is provided by a clinician within the same organization as the HCBS provider or care manager, there are firewalls between the HCBS/care management functions and the clinician, consistent with the principles of Conflict-Free Case Management (CFCM). Additionally, there must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

HCBS providers must develop and maintain a Service Plan for all HCBS provided. If a participant receives multiple HCBS, the goals for each service must be distinctly different from goals associated with other HCBS provided. Additional details about Service Plan and documentation requirements can be found in the Provider Service Delivery Documentation Policy for Children's HCBS.

HCBS providers should maintain documentation in the record to justify ongoing delivery of HCBS. This includes documentation of goals that have been accomplished through services so far, what is still needed to be accomplished, and what barriers are impacting participant outcomes, if applicable, as well as how these barriers are/will be resolved. The Service Plan must be updated to modify ongoing goals and timeframe and the care manager/HCBS provider is responsible for maintaining documentation that ongoing services are necessary.

Additional details on service necessity documentation requirements are provided in each of the service-specific sections below.

I. Continued Stay Criteria

Ongoing delivery of HCBS is appropriate when the participant remains Waiver eligible and either of the following criteria are met:

- the participant/family is making progress but has not fully reached established service goals and there is a reasonable expectation that continued services will increase the likelihood of the participant meeting the service goals, **or**
- the participant is at risk of losing skills gained if the service is not continued.

Additional details on continued stay criteria are provided in each of the service-specific sections below.

J. Service Discharge Criteria

Discharge from an HCBS is appropriate when any of the following apply:

- Participant/family has successfully met their specific goal outlined in their Service Plan and no longer needs the service, OR
- Participant no longer meets Children's Waiver eligibility criteria, transitions to OPWDD waiver services, or is admitted to an excluded residential or institutional setting, OR
- Participant/family no longer wishes to receive the service or withdraws consent for the service, or transitions to other more appropriate services, OR
- Participant is no longer engaged in the service despite multiple attempts on the part of the provider to apply reasonable engagement strategies.

Additional details on service discharge criteria are provided in each of the service-specific sections below.

IV. Community Habilitation

A. Definition

Habilitation Services are designed to assist participants to acquire, retain, and improve skills necessary to reside successfully in home and community-based settings. Activities are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.

Community Habilitation is an in-person service intended to support the participant's acquisition, maintenance, and enhancement of skills necessary to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or Health-Related Tasks. The service is delivered in the community (non-certified) settings.

Acquisition refers to the development of a new skill intended to foster greater independence by allowing a participant to perform the task for him or herself. There should be a reasonable expectation that the individual will acquire the skills necessary to perform that task within the authorization period.

Maintenance means preventing or slowing regression in the participant's skill level and to prevent loss of skills necessary to accomplish identified tasks.

Enhancement activities are provided through training and demonstration to promote growth and independence with an already acquired skill level and to support the participant's goal outside of the training environment.

Habilitation services, defined above, are distinguished from Rehabilitation services, which are services intended to restore and improve skills and function that have been lost or impaired. Participants whose skill performance has been impacted due to behavioral health conditions must be served using Psychosocial Rehabilitation, a State Plan service, rather than Habilitation Services in the waiver.

B. Service Components

Individuals appropriate for this service will have an assessed need for support with age-appropriate ADLs, IADLs, or Health-Related Tasks, beyond supports necessary to support typical child development. This service is intended to maximize personal independence and integration in the community, preserve functioning, and prevent the likelihood of future institutional placement. Skill acquisition, maintenance, and enhancement services are appropriate for participants who have the capacity to learn to live in the community, with or without support. It is not permissible for this service to be used solely for the HCBS provider to complete the ADLs/IADLs listed below on behalf of the participant. Instead, the service must be geared towards teaching and/or enhancing the skills of the participant to increase their capacity to complete the ADLs/IADLs on their own. Goals associated with this service should outline specific objectives to be

achieved through acquisition, maintenance, and enhancement of skills associated with age-appropriate ADLs, IADLs and Health-Related Tasks. Service delivery should be based on a prepared curriculum with a predictive goal achievement timeframe that can be altered towards the individual's needs, development, and experience and monitoring of progress.

ADLs, are basic self-care tasks that include:

- Walking and/or otherwise getting around the home or outside.
- Feeding, as in being able to get food from a plate into one's mouth.
- Dressing and grooming including selecting clothes, putting them on, and adequately managing one's personal appearance.
- Toileting, including getting to and from the toilet, using it appropriately, and cleaning oneself.
- Bathing/hygiene including washing face and body in the shower or bath.
- Transferring, defined as being able to move from one body position to another. This includes being able to move from a bed to a chair, or into a wheelchair. This can also include the ability to stand up from a bed or chair in order to grasp a walker or other assistive device.

IADLs are self-care tasks that include:

- Managing finances, such as paying bills, budgeting, banking, and managing financial assets.
- Managing transportation, either via driving or by taking other means of transport in the community.
- Shopping and meal preparation, this covers everything required to get a meal on the table. It also covers shopping for clothing and other items required for daily life.
- Housecleaning and room/home maintenance, this means cleaning kitchens after eating, keeping one's living space reasonably clean and tidy, and keeping up with home maintenance.
- Managing communication, such as the telephone, mail and electronic forms of communication.
- Managing medication, including obtaining medications and taking them as directed, including pouring, administering, and recording medications.
- Learning the skills needed to maintain personal safety in the home and community such as safety procedures, emergency contacts and responses.
- Health management skills, including performing simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; assisting with the use of medical equipment, supplies, and devices; assisting with special skin care; assisting with a dressing change; assisting with appointments, and how to prepare for a medical appointment (sharing information of effects of condition/medication, etc. and asking questions).

- Interacting with members of the community and maintaining religious practices, hobbies, or other interests.

Health Related Tasks include:

- Performing simple measurements and tests;
- Assisting with the preparation of complex modified diets;
- Assisting with a prescribed exercise program;
- Pouring, administering and recording medications;
- Assisting with the use of medical equipment, supplies and devices;
- Assisting with special skin care;
- Assisting with a dressing change; and
- Assisting with ostomy care.

Examples of appropriate Community Habilitation activities include:

- Providing opportunities for participants to acquire, retain, or strengthen age-appropriate socialization skills, communication skills, and/or adaptive skills that support their independence and involvement in the community.
- Teaching age-appropriate activities of daily living including hygiene tasks, establishing routines, dressing appropriately, etc.
- Teaching participants how to complete age-appropriate daily tasks such as laundry, cooking, personal hygiene, etc.
- Teaching participants how to manage age-appropriate health-related tasks, such as taking medications, preparing healthy meals, or using adaptive/assistive technology.
- Teaching and practicing age-appropriate time management, planning skills, and developing systems for managing tasks/scheduling (i.e. activity charts, etc.).

When Community Habilitation is provided to help a participant acquire the skills to navigate travel from one location in the community to another, this service may include the assistance provided by a direct care worker to accompany the participant while learning the skill. The in-person service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Community Habilitation service.

C. Modality

Individual Community Habilitation is provided in-person by 1 staff member to 1 participant.

Group Community Habilitation is provided in-person by 1 staff member to up to 3 participants. Participant to staff ratio cannot exceed 3:1. The group modality is only appropriate if participants in the group have similar goals and the group activities are appropriately geared toward the goals of all members of the group.

D. Setting

Refer to *Requirements Applicable to All Services*.

These services can be delivered in community settings. Such settings include, but are not limited to the participant's home, which may be owned or rented, or a work setting. This service cannot be provided in a OPWDD certified setting, regardless of where the participant resides.

E. Limitations/Exclusions and Utilization

Refer to Requirements Applicable to All Services.

Community Habilitation is limited to 6 hours (24 Units) per day (all Community Habilitation combined), 12 hours (48 Units) per month (all Community Habilitation combined), and 144 hours (576 Units) per calendar year (all Community Habilitation combined). However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

Ages 0 through 6

- Anticipated Utilization: (0 units) per month (all Community Habilitation combined),

At this age, skill building is typically met through parental support/natural caregivers and use of services such as Early Intervention (EI) and daycare/preschool services. If Habilitative services are necessary at this age, they are typically provided by licensed practitioners including Occupational Therapy, Physical Therapy, and Speech Therapy, not Community Habilitation.

Ages 7 through 13

- Anticipated Utilization: 0-6 hours (24 units) per month (all Community Habilitation combined),

At this age, Community Habilitation typically involves reinforcing skills, behaviors, or lessons taught in other settings, supporting skill development and retention when not available through BOCES, or other school/community programming. It may include reinforcing or practicing skills and abilities associated with physical, occupational, or speech therapies, if the direct support provider is appropriately trained, or supports with time management, hygiene, and organization for school and home life, supporting a developmentally appropriate level of independence,

Ages 14 through 20

- Anticipated Utilization: 0-12 hours (48 units) per month (all Community Habilitation combined)

At this age, Community Habilitation typically involves supports with time management, hygiene, and organization for school and home life and/or supports for developmentally appropriate independence, including transition into adulthood/independent living, when not available through BOCES, or other school/community programming.

F. Certification/Provider Qualifications

Provider Agency Qualifications

Refer to *Requirements Applicable to All Services*.

Agencies must also be certified by the New York State Office for People with Developmental Disabilities (OPWDD).

Individual Staff Qualifications

Refer to *Requirements Applicable to All Services*.

Community Habilitation services will be performed by direct care workers who meet the licensure and certification requirements for providers approved by OPWDD to provide Community Habilitation.

Direct support professionals must be employed by the designated agency and have completed the training stipulated in 14 NYCRR 633.8 and the Direct Support Professionals Core Competencies curriculum.

Additional information can be found in the DSP Core Competencies section of the OPWDD website.

G. Service Admission Requirements

Refer to *Requirements Applicable to All Services*.

The HCBS Provider must conduct an assessment of the participant's functional level of ADLs/IADLs to determine the support that is needed and to establish goals and objectives and determine when they are met.

Community Habilitation may be provided when the following criteria are met:

- There is evidence of an assessed need for support to build skills to independently complete age-appropriate ADLs or IADLs which may include a diagnosis of a developmental disability by a licensed practitioner, an assessment from a licensed professional noting delays in completing ADLs, or IADLs which are not associated with age; or other evidence justifying the need for support with ADLs or IADLs beyond supports necessary to support typical child development.

- The identified need can be met by a habilitation service focused on gaining, keeping, and improving ADL, IADL, or health-related skills of the individual.
- Community Habilitation is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) to enhance the participant's ability to carry out ADLs, IADLs, or Health-Related Tasks independently.
- The activities are for the sole benefit of the participant and are only provided to the participant receiving HCBS.
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence.
- The activities provided are in support of skill acquisition, maintenance or enhancement of skills and coordinated with the performance of ADLs, IADLs, and health-related tasks.
- Training for skill acquisition, maintenance, and enhancement activities that involve the management of behaviors must not use punitive methods.

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for supports with ADLs, IADLs, or Health-Related Tasks.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record that indicates an assessed need for support to build skills to independently complete age-appropriate ADLs, IADLs, or health-related tasks at the frequency, scope, and duration requested.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation from a licensed professional involved in the child's care noting delays in completing age-appropriate ADLs or IADLs and the need for support, which is not associated with age.
- Documentation outlining consideration of other school programming or documentation that additional support out of school to assist to re-enforce/maintain skills being taught.
- Consideration to transition to the OPWDD services (documentation from OPWDD indicating start of transfer process).
- Documentation of youth's graduation or discontinuance in K-12 educational services, if applicable.

Exceeding the service limits (i.e., annual, daily, monthly) for this service would not be expected.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services*.

- Documentation outlining consideration of other school programming or documentation that additional support out of school to assist to re-enforce/maintain skills being taught.
- Consideration to transition to the OPWDD services; OR
- Documentation of youth's graduation or discontinuance in K-12 educational services, if applicable.

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services*.

V. Day Habilitation

A. Definition

Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills necessary to support age-appropriate Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) including communication, and travel that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills necessary to reside successfully in home- and community-based settings including appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice.

Day Habilitation (DH) services must be provided to a participant at an OPWDD-certified setting typically between the hours of 9 a.m. and 3 p.m.

B. Service Components

Day Habilitation services (Group and Individual) focus on enabling the participant to attain or maintain his or her maximum functional level. In addition, Day Habilitation may reinforce skills, behaviors, or lessons taught in other settings. Day Habilitation fosters the acquisition of ADL and IADL skills necessary to reside successfully in home- and community-based settings including appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice.

Individuals appropriate for this service will have an assessed need for support to build skills to independently complete age-appropriate ADLs or IADLs beyond supports necessary to support typical child development. This service is intended to maximize personal independence and integration in the community, preserve functioning, and prevent the likelihood of future institutional placement. Skill acquisition, maintenance, and enhancement services are appropriate for participants who have the capacity to learn to live in the community, with or without support. It is not permissible for this service to be used solely for the HCBS provider to complete the ADLs/IADLs listed below on behalf of the participant. Instead, the service must be geared towards teaching and/or enhancing the skills of the participant to increase their capacity to complete the ADLS/IADLs on their own.

ADLs, are basic self-care tasks that include:

- Walking and/or otherwise getting around the home or outside.
- Feeding, as in being able to get food from a plate into one’s mouth.
- Dressing and grooming including selecting clothes, putting them on, and adequately managing one’s personal appearance.
- Toileting, including getting to and from the toilet, using it appropriately, and cleaning oneself.

- Bathing/hygiene including washing face and body in the shower or bath.
- Transferring, defined as being able to move from one body position to another. This includes being able to move from a bed to a chair, or into a wheelchair. This can also include the ability to stand up from a bed or chair in order to grasp a walker or other assistive device.

IADLs are self-care and health-related tasks that include:

- Managing finances, such as paying bills, budgeting, banking, and managing financial assets.
- Managing transportation, either via driving or by taking other means of transport in the community.
- Shopping and meal preparation, this covers everything required to get a meal on the table. It also covers shopping for clothing and other items required for daily life.
- Housecleaning and room/home maintenance, this means cleaning kitchens after eating, keeping one's living space reasonably clean and tidy, and keeping up with home maintenance.
- Managing communication, such as the telephone, mail and electronic forms of communication.
- Managing medication, including obtaining medications and taking them as directed, including pouring, administering, and recording medications.
- Learning the skills needed to maintain personal safety in the home and community such as safety procedures, emergency contacts and responses.
- Interacting with members of the community and maintaining religious practices, hobbies, or other interests.

Examples

- Providing opportunities for participants to acquire, retain, or strengthen socialization skills, communication skills, and/or adaptive skills that foster independence and community living.
- Teaching activities of daily living including hygiene tasks, establishing routines, dressing appropriately, etc.
- Teaching participants how to complete daily tasks such as laundry, cooking, personal hygiene, etc.

Specific objectives/activities with timeframes must be outlined to demonstrate how the goal/outcome for the service will be obtained. Due to the nature of the service, more short-term goals/outcomes may need to be identified to address the overall need. Providers must outline how various short-term goals/outcomes will meet the overall need and support longer-term goals. Service delivery should be based on a prepared curriculum with a predictive goal achievement timeframe that can be altered towards the individual's needs, development, and experience and monitoring of progress.

C. Modality

Individual Day Habilitation is provided in-person by 1 staff member to 1 participant.

Group Day Habilitation is provided in-person by 1 staff member to up to 3 participants. Participant to staff ratio cannot exceed 3:1. The group modality is only appropriate if participants in the group have similar goals and the group activities are appropriately geared toward the goals of all members of the group.

D. Setting

Refer to *Requirements Applicable to All Services*.

Day Habilitation (DH) services are provided **only** at locations certified by OPWDD to provide site-based Day Habilitation. Day Habilitation Without Walls (i.e. Day Habilitation that takes place outside of a site-based setting) is not a component of Children's Waiver Day Habilitation.

E. Limitations/Exclusions and Utilization

Refer to *Requirements Applicable to All Services.*

Regular Day Habilitation (DH) takes place during the hours of 9 A.M. and 3 P.M. Monday through Friday. Supplemental DH services are those services provided on weekends and/or on weekdays with a service start time after 3 P.M. Supplemental DH services are not available to individuals residing in certified residential settings with paid, professional staff, because the certified residential habilitation provider is responsible for the habilitation needs of the individual on weekday evenings and anytime on weekends. The same billing codes are used for Regular DH and Supplemental DH.

Day Habilitation Services are limited to 6 hours (24 units) per day (all Day Habilitation combined), 12 hours (48 Units) per month (all Day Habilitation Combined), and 144 hours (576 Units) per calendar year (all Day Habilitation Combined). However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

Ages 0 through 6

- Anticipated Utilization: 0 hours (0 units) per month (all Day Habilitation combined),

At this age skill building needs are typically met through parental support/natural caregivers and use of services such as Early Intervention (EI), Preschool Supportive Health services, School Supportive Health services, or other educational/ school programs. Services necessary at this age typically are provided by licensed practitioners including Licensed Behavior Analyst, Occupational Therapists, Physical Therapist, and Speech Therapists.

Ages 7 through 13

- Anticipated Utilization: 0-6 hours (24 units) per month (all Day Habilitation Combined)

At this age, Day Habilitation typically involves reinforcing skills, behaviors, or lessons taught in other settings, supporting skill development and retention. It may include reinforcing or practicing skills and abilities associated with physical, occupational, or speech therapies, if the direct support provider is appropriately trained. It may also include supports with time management, hygiene, and organization for school and home life or supports for developmentally appropriate independence, when not available through BOCES, or other school/community programming.

Ages 14 through 20

- Anticipated Utilization: 0-12 hours (48 units) per month (all Day Habilitation Combined)

At this age, Day Habilitation typically involves skill development, with a focus on independence/life skills (not to replace prevocational service), when not available through BOCES, or other school/community programming. It may also include supports with time management, hygiene, and organization for school and home life.

F. Certification/Provider Qualifications

Provider Agency Qualifications

Refer to *Requirements Applicable to All Services*.

Agencies providing this service must also be certified by OPWDD.

Individual Staff Qualifications

Refer to *Requirements Applicable to All Services*.

Direct support professionals must have completed the training stipulated in 14 NYCRR 633.8 and the Direct Support Professionals Core Competencies curriculum. Additional information about this curriculum can be found in the DSP Core Competencies section of the OPWDD website.

G. Service Admission Requirements

Refer to *Requirements Applicable to All Services*.

The HCBS Provider must conduct an assessment of the participant's ability to manage age-appropriate ADLs/IADLs to determine the support that is needed and to establish age-appropriate goals and objectives and determine when they are met.

Day Habilitation may be provided when the following criteria are met:

- There is evidence of an assessed need for support to build skills to independently complete age-appropriate ADLs or IADLs, which may include an assessment from a licensed professional noting delays in completing ADLs or IADLs, which are not associated with age; or other evidence justifying the need for support with ADLs or IADLs beyond supports necessary to support typical child development.
- The need to build, maintain, or improve skills necessary to reside successfully in home- and community-based settings including appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice skills has been assessed, determined, and authorized as part of the person-centered planning process.
- Day Habilitation is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) to enhance the participant's ability to reside independently in home-based settings or to successfully participate in community activities.
- The activities are for the sole benefit of the participant and are only provided to the participant receiving HCBS.
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the participant has a progressive medical condition.
- Training for skill acquisition, maintenance, and enhancement activities that involve the management of behaviors must use positive reinforcement techniques.
- When Day Habilitation is provided to help a participant acquire the skills to navigate travel from one location in the community to another, this service may include the assistance provided by a direct care worker to accompany the participant while learning the skill. The in-person service time when a direct care worker is assisting or providing transportation to an individual may also be billed as part of the Day Habilitation service.
- Consideration of other school programming or documentation that additional support out of school to assist to re-enforce/maintain skills being taught is maintained.

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for support to build skills to independently complete age-appropriate ADLS or IADLs.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need for support to build skills to independently complete age-appropriate ADLs or IADLs, at the frequency, scope, and duration requested.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation from a licensed professional involved in the child's care noting delays in completing age-appropriate ADLs or IADLs and the need for support, which is not associated with age.
- Documentation outlining consideration of other school programming or documentation that additional support out of school to assist to re-enforce/maintain skills being taught.
- Consideration to transition to the OPWDD services (documentation from OPWDD indicating start of transfer process).
- Documentation of youth's graduation or discontinuance in K-12 educational services, if applicable.

Exceeding the service limits (i.e., annual, daily, monthly) for this service would not be expected.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services*.

Documentation substantiating continued need for ongoing support to build skills to independently complete age-appropriate ADLs and/or IADLs

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services*.

VI. Caregiver/Family Advocacy and Support Services

A. Definition

Caregiver/Family Advocacy and Support Services (CFASS) are short-term interventions to train, coach, and educate the enrolled participant's caregivers and family related to the medical, physical, developmental, or behavioral health condition that puts them at risk of institutionalization. These temporary services develop and implement strategies and interventions that will result in the reduction of stress associated with caring for the child/youth's complex needs while building resilience to better care for the child/youth. These services will also assist the participant, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their condition(s) or disability(ies) that put them at risk of institutionalization.

Caregiver/Family Advocacy and Support Services enhance the participant's ability to function as part of a caregiver/family unit and community at-large; and enhance the caregiver/family's ability to care for the participant in the home and/or community and provides the participant, family, caregivers, and collateral contacts (family members, caregivers, and other stakeholders identified on the participant's POC) with techniques and information so that they can better respond to the needs of the participant and reduce the risk of institutionalization.

Participating in community events and integrated interests/occupations are important activities for all participants, including those with disabilities (developmental, physical, and/or behavioral health in origin). Success in these activities is dependent not only on the participant, but on the people who interact with and support the participant in these endeavors. Caregiver/Family Advocacy and Support Services improve the participant's ability to gain from experiences in the community and enables the participant's environment to respond appropriately to the participant's disability and/or healthcare issues.

The POC and Service Plan objectives must clearly state how the service can address the need for specific training, coaching, or education related to the participant's condition and/or diagnoses and the overall goal of the participant/family.

B. Service Components

Based upon the Caregiver/Family Advocacy and Support Services plan developed by the participant and caregiver/family team, this service provides opportunities to:

- Interact and engage with family/caregivers and participants to offer educational, advocacy, and support resources to develop family/caregivers' ability to independently access community services and activities.
- Maintain and encourage the caregivers'/families' self-sufficiency in caring for the participant in the home and community.

- Coach and support follow-up regarding another provider's treatment, counseling, guidance, etc. for the participant, caregivers and other family identified individuals.
- Educate and train the caregiver/family unit on available tools/strategies so that they might better support the needs of the participant.
- Educate and train family members or other individuals identified by the family of the participant's chronic condition, medical, developmental, and behavioral needs, so they may assist the family unit and provide support and respite (e.g., training for Consumer Directed Personal Assistance Services (CDPAS)).
- Provide guidance in the principles of living with participant's chronic condition or illness.
- Train (one-on-one or group) the participant or the family/caregiver regarding methods and behaviors to enable success in the community; each group must not exceed three eligible children/youth or 12 individuals (children and collaterals).
- Provide direct training in the community with collateral contacts regarding the participant's disability(ies) and needs related to his or her health care issues.
- Provide self-advocacy training for the participant and/or family/caregiver, including during community transitions.
- Attend and support participants and caregivers in meetings with professionals regarding the child's complex needs, such as IEP meetings or medical appointments.

The service can be delivered to multiple family members or other collateral contacts identified for the participant to address the family's needs.

When the member's Plan of Care includes both Level 1 and Level 2 services, the HCBS provider must document how the services support the participant's goals, why the services are delivered in this way, why the services from more than one practitioner are needed, and how the services are inter-related. The need for two practitioners should reflect the child/youth's and/or family/caregiver's needs and align with the Plan of Care (POC) and HCBS Service Plan goals. Whether the service will be provided by a Level 1 or Level 2 practitioner must reflect the needs of the participant/caregiver. Level 2 is only appropriate if the services and supports provided to a caregiver or participant requires the training and experience of a Level 2 practitioner, which must be documented in the member's record.

When two practitioners deliver CFASS simultaneously:

- Each practitioner must address different goals or aspects of the service.
- The service and goals for each practitioner must be clearly documented in the child/youth's progress notes.
- The practitioner/child and practitioner/collateral must be located in physically separate spaces (i.e. all 4 individuals could not be engaged in the same activity).

In instances where two practitioners are required to meet the needs of the participant/family, and the encounters occur at the same date and time, the agency can bill for both practitioners in one claim by adding the time the service was delivered by each practitioner into a combined claim. If one practitioner delivers the services to a participant and/or multiple family members/ resources at the same date and time, the claim should reflect the exact time spent as a single encounter.

Examples

- Educate other involved individuals (e.g., the participant's after school club instructor, soccer coach, etc.) on effective strategies to support the participant related to their chronic condition, medical, developmental, and behavioral needs.
- Provide coaching and support within the home environment as follow-up and reinforcement of strategies, guidance, directions, etc. taught, shared, developed, or directed by another professional involved in the member's care, such as a teacher or physical therapist.
- Attend school IEP Meetings to provide additional support to caregivers who are advocating for the participant's needs.
- Training of family members and other involved adults on participant's condition/how to care for participant's needs to enhance their ability to support the family.
- Host or participate in workgroups/classes along with the participant/caregiver that develop/strengthen understanding of a participant's medical, developmental or behavioral health needs that put them at risk of institutionalization.

C. Modality

Individual Caregiver Family Advocacy and Support Services is delivered in-person to 1 participant/collateral.

Group Caregiver Family Advocacy and Support Service is delivered in-person to up to 3 participants/collaterals. Participant to staff ratio cannot exceed 3:1 (each group must not exceed three eligible children/youth or 12 individuals (children and collaterals)). The group modality is only appropriate if participants in the group have similar goals and the group activities are appropriately geared toward the goals of all members of the group.

Note: Services can be delivered with or without the participant present.

D. Setting

Refer to *Requirements Applicable to All Services*.

E. Limitations/Exclusions and Utilization

Refer to *Requirements Applicable to All Services*.

While Caregiver/Family Advocacy and Support Services (CFASS) can be used to help prepare the participant/family for Individualized Education Program (IEP) meetings, or attend IEP meetings with the caregiver, this service cannot be used to develop an IEP, the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the participant.

Caregiver/Family Advocacy and Support Services cannot duplicate or replace the role of the participant's care manager. The Care Manager remains responsible for system navigation, linkages to community resources, and collaboration with care team members/involved service providers.

Caregiver/Family Advocacy and Support Services (CFASS) is limited to 6 hours (24 units) per day (all CFASS combined),12 hours (48 Units) per month (all CFASS combined), and 144 hours (576 Units) per calendar year (all CFASS combined). However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

Ages 0 through 8

- Anticipated Utilization: 0-12 hours (48 units) per month (all CFASS combined)

At this age, CFASS typically involves training, education, and coaching to the caregivers, family members, collaterals regarding the specific needs of the participant. CFASS goals/objectives should be specific to the caregivers', family members', and collaterals' education and training regarding the identified needs. This type of training and support provided to a participant is not generally appropriate for children under the age of 9.

Ages 9 through 20

- Anticipated Utilization: 0-12 hours (48 units) per month (all CFASS combined)

At this age, CFASS may involve training, education, and coaching of the caregivers, family members, collaterals, or the participant regarding the specific needs of the participant.

F. Certification/Provider Qualifications

Provider Agency Qualifications

Refer to *Requirements Applicable to All Services.*

Individual Staff Qualifications

Level 1

- **Minimum Qualifications:** Requires a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g., SACC or CDOS) with related human service experience.
- **Preferred Qualifications:** Experience working with children/youth.

Level 2

- **Minimum Qualifications:** Requires a bachelor's degree plus two years of related experience.
- **Preferred Qualifications:** Requires a master's degree in education, or a master's degree in a human services field plus one year of applicable experience.

Supervisor Qualifications

Level 1

- **Minimum Qualifications:** Requires a bachelor's degree with one year of experience in human services working with children/youth.
- **Preferred Qualifications:** Two years' experience in human services working with children/youth.

Level 2

- **Minimum Qualifications:** Requires a master's degree with one year of experience or a bachelor's degree with four years of experience in human services working with children/youth.
- **Preferred Qualifications:** Master's degree with two years of experience in human services working with children/youth.

G. Service Admission Requirements

Refer to *Requirements Applicable to All Services.*

CFASS may be provided when the following criteria are met:

- The need for coaching or training has been assessed, determined, and authorized as part of the person-centered planning process.
- CFASS is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) to enhance the participant's ability, regardless of condition/disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the participant in the home and/or community.
- The activities support the caregivers'/families' self-sufficiency in caring for the participant in the home and community.

- The Service Plan outlines specific training, coaching and educational objectives and planned activities that support the goal and the expected timeframe for achieving the goal.

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for training, coaching, or education support aligned with the service definition.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need. The assessment must include the specific training, coaching, or education needs related to the participant's medical, physical, developmental or behavioral health condition that puts them at risk of institutionalization and must support the frequency, scope and duration requested.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation from a licensed professional involved in the child's care (i.e. pediatrician or other licensed practitioner, school professional, etc.) noting the need for training, coaching or education support related to the participant's medical, physical, developmental, or behavioral health condition that puts them at risk of institutionalization.
- Documentation from a care manager of the specific identified assessed needs and the desired outcome.

Supporting documentation of the timeframe and curriculum or training/education techniques that are utilized must be documented in the participant record. If training/ education to family members or collaterals is needed, then specific documentation regarding the goal and the connection to participant's need must also be documented. For example, if CFASS is being provided to assist with training a Consumer Directed Personal Assistance Services (CDPAS) provider, this must be clearly outlined in the record.

CFASS utilization that exceeds the service limits (i.e., annual, daily, monthly), must be necessary to prevent institutionalization and support the child remaining in the home/community, and must be justified by documentation provided by a third-party entity involved in the participant's care. Such documentation may include but is not limited to the documentation types listed above.

Additionally, there must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services.*

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services.*

VII. Respite

A. Definition

This service provides short-term assistance to families of participants because of the absence of or need for relief of the participant or the participant's family caregiver. HCBS respite provides short-term relief for primary caregivers who are responsible for parenting participants with significant medical, physical, developmental, or behavioral health needs that put the participant at risk of institutionalization. Respite enhances the family or primary caregiver's ability to support the participant's functional, developmental, behavioral health, and/or health care needs. Additionally, respite helps build stability in the family unit by avoiding disruptions in a participant's home environment and supporting the family in being able to care for the participant at home.

Respite workers provide appropriate temporary care and supervision to protect the participant's safety in the absence of family members or caregivers and engage the participant in participant-centered care directly related to the participant's unique abilities and circumstances. It is important that the respite worker has a knowledge of and understanding of the participant's particular needs and abilities to provide activities that support his/her and/or primary caregiver/family's constructive interests and abilities.

Respite providers regularly communicate with other providers to maintain familiarity with the participant's goals.

B. Service Components

Refer to *Requirements Applicable to All Services*.

Respite can be provided in a planned mode or delivered in a crisis situation.

Respite is not a substitute for routine childcare.

Planned

Planned Respite services provide planned short-term relief for the participant or family/primary caregivers to enhance the family/primary caregiver's ability to support the participant's functional, developmental, behavioral health, and/or health care needs and maintain the participant in the home and community. The service is direct care for the participant by individuals trained to support the participant's needs. This support may occur in short-term increments of time (usually during the day outside school hours) or on an overnight or longer-term increment. Planned Respite activities support the POC goals and include providing supervision and activities that match the participant's developmental stage and continue to maintain the participant's health and safety.

Crisis Respite

Crisis Respite is a short-term care and intervention strategy for participants and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. It may be used when challenging behavioral or situational crises occur that the participant and/or family/caregiver is unable to manage without intensive assistance and support. Crisis Respite should be included on the POC to the extent that it is an element of the crisis/safety plan or risk mitigation strategy. Crisis Respite should only be used in response to an immediate crisis.

Ongoing communication between participant or the family/primary caregiver receiving Crisis Respite for their child, the Crisis Respite staff, and the participant's established behavioral health and healthcare providers are required to assure collaboration and continuity in managing the crisis situations and identifying subsequent support and service needs, as well as the anticipated end date for the crisis respite.

At the conclusion of a Crisis Respite period, Crisis Respite staff, together with the participant and family/primary caregiver, and his or her established behavioral health or health care providers when needed, will make a determination as to the continuation of necessary care and make recommendations for modifications to the participant's POC. Crisis Respite should be provided in the most integrated and cost-effective settings appropriate to meet the respite needs of the participant/family. Out-of-home Crisis Respite is not intended as a substitute for permanent housing arrangements.

Since Respite Services are short term services to provide relief to the caregiver or participant, it is incumbent for the HHCM/C-YES' plan of care to have goals to build supports and/or obtain other resources for the family/participant to support them long-term.

Overnight Respite

Overnight Respite is defined as Respite services provided to a person on two consecutive days when Respite staff are providing supervision of a participant during nighttime hours.

Overnight Respite may be used to enhance the family/primary caregiver's ability to support the participant's functional, developmental, behavioral health, and/or health care needs or to help alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment by giving the caregiver a break for caring for a child with complex needs.

HCBS providers must have clear documentation for the need of overnight respite and the risk being alleviated by overnight respite.

Note: Utilization of overnight respite for supervision “in case” there is a situation or if the participant has elopement concerns is not an appropriate use of overnight respite.

Examples

- Engaging the participant in recreational activities (i.e. games, arts and crafts, sports) while parent/caregiver receives a break.
- Engaging the participant in community events and visiting community attractions (i.e. visiting the local park, participation in an event at the local library, spending time at the YMCA, etc.) while parent receives a break
- Engaging the participant in activities that will strengthen adaptive skills (that are Identified on the Plan of Care) while parent receives a break
- Overnight Respite: Providing a safe space for participant to sleep overnight when their caregiver undergoes surgery that renders them unavailable to care for the child for 24 hours.
- Crisis Respite: As a part of the participant’s safety plan, the Crisis Respite provider offers the participant an opportunity for a safe space from their home environment. The Respite provider engages the participant in safe activities to assist the participant in de-escalation.

C. Modality

Refer to *Requirements Applicable to All Services*.

Individual Respite is provided by 1 staff member to 1 participant.

Group Respite is provided by 1 staff member to up to 3 HCBS participants. Participant to staff ratio cannot exceed 3:1.

D. Setting

Refer to *Requirements Applicable to All Services*.

Planned or Crisis Day Respite services can be provided in the home of an eligible participant or a community setting. Community settings may include areas where a participant lives, attends school, works, engages in services and/or socializes.

Respite services may be delivered in the participant's home or residence by qualified practitioners, out-of-home/residence by staff in community-based sites (e.g., community centers, parks), or in allowable facilities.

Crisis Respite services may be delivered in the participant's home or residence by qualified practitioners, out-of-home/residence by staff in community-based sites, or in allowable facilities. Services offered may include site-based crisis residence, monitoring for high-risk behavior, health and wellness skill building, wellness activities, family/caregiver support, conflict resolution, and other services as needed.

Note: a provider can be designated for Crisis or Planned Respite without an overnight setting; however, they will only be authorized to provide Respite that does not include an overnight stay or overnight service provision. If the Respite service is provided overnight, it can only be done so in an authorized overnight setting, and that setting must be a licensed/certified facility as outlined below.

Planned or Crisis Overnight Respite settings include those licensed or certified by OCFS, OMH, or OPWDD and designated to provide Respite services. Please note there is an exemption in the CMS HCBS Final Rule (March 16, 2014) for allowable Respite care settings.

- OMH licensed Children's Community Residence (community-based or state-operated), which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594
- OMH licensed Children's Crisis Residence (community-based or state-operated), which has an OMH Operating Certificate demonstrating compliance with 14 NYCRR 589*
- OCFS-Licensed agency boarding home, group home, group residence, or institution, or certified foster boarding homes.
- OPWDD certified residential setting where the individual does not permanently reside (i.e., Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD).

Billing for overnight Respite is allowable in the settings listed above only for participants who are not residents of these settings. Agencies designated to provide Respite and any of the residential services listed above cannot bill for both services provided to the same participant simultaneously.

E. Limitations/Exclusions and Utilization

Refer to *Requirements Applicable to All Services*.

Services to participants in foster care must comply with Part 435 of 18 NYCRR. When HCBS respite is provided for the relief of a foster care provider, foster care respite services may not also be billed for the same time period. However, should additional respite in excess of foster care respite be necessary to meet needs of the participant or caregiver, due to the child's complex condition, HCBS respite may be utilized.

Respite is not an allowable substitute for permanent housing arrangements.

Participants living independently are not eligible to receive Respite.

Respite is not a substitute for routine childcare. In scenarios where the parent/caregiver otherwise routinely needs childcare (e.g., during their workday if they work apart from their child), respite is not permitted. If provided before and/or after school, the need for Respite must be documented: why the service will be provided in the morning (before school) and in the afternoon (after school). Respite cannot be connected to the caregiver's work schedule.

Respite is not an allowable substitute for medically necessary care or treatment in a residential or institutional setting. For instance, although an OMH licensed Children's Crisis Residence can be used for HCBS Respite services, HCBS respite should only be billed if a child does not otherwise meet admission criteria for the Crisis Residence service. If the child meets the admission criteria for the Crisis Residence, they must be admitted to the Crisis Residence and the service must be billed under the Crisis Residence benefit.

Respite workers may attend to the participant's medical and non-medical needs and other ADLs which would ordinarily be performed by a caregiver or family member. However, unlicensed Respite workers are not permitted to utilize medical equipment, administer medications, or utilize medical devices without appropriate training by a licensed professional. If requested by the family, determined appropriate by a clinician, and approved by the designated Respite agency, an appropriately licensed professional such as a registered nurse, physical therapist, or occupational therapist may provide training to the Respite staff member to provide limited medical supports that do not require licensure. Documentation of staff training must be maintained in the participant/staff record. Some examples of care that Respite workers for medically fragile participants can provide include turning and repositioning youth with limited mobility, and assistance with home exercise plan as guided by a therapist (OT, PT, ST, etc.). These activities are only permissible if provided for the sole purpose of supporting the participant's needs while providing a break to the primary caregiver.

Payment may not be made for Respite provided at the same time when other services that include care and supervision are provided. For example, a provider may not bill for community habilitation and respite provided to the same participant at the same time. Both services can be billed on the same date, but only if they are provided at different times that do not overlap during the day.

Respite Services are limited to 28 hours per month (all Respite combined), and 336 hours per calendar year (all Respite combined). However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

When Respite is provided simultaneously to another Medicaid service, documentation must be present in the record to indicate the rationale/justification for service delivery in this manner.

Ages 0 through 6

- Anticipated Utilization: 0-6 hours per month (all Respite combined).

At this age, Respite services typically involve provision of a planned break to assist in managing an identified need for relief from stressors of caring for a child with complex needs.

Ages 7 through 17

- Anticipated Utilization: 0-28 hours per month (all Respite combined).

At this age, Respite services typically involve provision of a planned break to assist in managing an identified need for relief from stressors of caring for a child with complex needs who requires supervision.

Ages 18 through 21

- Anticipated Utilization: 0-15 hours per month (all Respite combined).

At this age, Respite services typically involve provision of a planned break to assist in managing an identified need for relief from stressors of caring for a youth with complex needs who requires supervision.

F. Certification/Provider Qualifications

Refer to *Requirements Applicable to All Services*.

For Overnight Planned or Crisis Respite, must also be one of the following:

- OMH-certified Community Residence: (community-based or State-operated) including Crisis Residence

- OCFS licensed/certified setting including agency boarding home, a group home, a group residence, or an institution.
- OPWDD certified residential setting.

Individual Staff Qualifications

Refer to *Requirements Applicable to All Services*.

Minimum qualifications for providers of services in participant residence or other community-based setting (e.g., park, shopping center, etc.)

- Respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training. It is the responsibility of the HHCM/C-YES to ensure that providers have adequate training and knowledge to address the individual child/youth's needs (including but not limited to physical and/or medical needs such as medications or technology).
- Experience working with children/youth (preference given to those with experience working with children/youth with special needs)
- A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS)

Minimum qualifications for providers of services outside child/youth's residence and in an allowable licensed/certified setting

- In foster boarding homes, respite providers must be Licensed Foster Parents pursuant to Part 435 of 18 NYCRR
- In OCFS licensed/certified settings, respite providers are paraprofessionals with a high school diploma or equivalent and with appropriate skills and training.
- In OMH licensed Children's Community Residences (community-based or State-operated), with an OMH Operating Certificate demonstrating compliance with 14 NYCRR 594, respite workers must be staff of the licensed program.
- In OMH licensed Children's Crisis Residence (community-based or State-operated) with an OMH Operating Certificate demonstrating compliance with 14 NYCRR 589, respite workers must be staff of the licensed program.
- In OPWDD-certified settings (community-based or State-operated), Family Care Home, Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD); Individualized Residential Alternative (IRA) or Community Residence (CR); or Free-Standing Respite facility under the auspices of OPWDD, respite workers must be staff of the certified program.

Supervisor Qualifications

An individual with a bachelor's degree and one or more years of experience in human services working with children/youth.

G. Service Admission Requirements

Refer to *Requirements Applicable to All Services*.

The following criteria must be considered in assessing whether respite services are appropriate. As with other HCB Services, the need for respite must be determined in the context of POC development, based on the individual needs of the child and family.

Specific criteria to be considered include:

- Severity of the child's disability and needs, including the need for supervision in the absence of the caregiver.
- Potential risk of out-of-home placement for the child if respite services are not provided.
- Lack of access to informal support systems such as extended family, supportive friends, community supports, etc.
- Lack of access to other sources of respite due to barriers such as waiting lists, and remote/inaccessible location of services.
- Presence of factors known to increase family stress, such as having only one caregiver, or having other family members with complex conditions.
- The perceived and expressed level of need for respite services by the primary caregiver.

The perceived need for respite services by the parent, in the absence of any other factors, is not a sufficient indicator of the need for respite.

Planned Respite may be provided when the following criteria are met:

- The need for provider relief from caregiving stressors beyond routine childcare has been assessed, determined, and authorized as part of the person-centered planning process.
- Respite is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s).
- The activities are for the sole benefit of the participant and caregiver and are only provided to the waiver-enrolled participant receiving respite.
- The activities are designed to preserve or enhance the caregiver's ability to care for the participant in the home.

Crisis Respite may be provided when the following criteria are met:

- Crisis Respite should only be used in response to an immediate crisis such as a challenging behavioral or situational crisis that the family/caregiver is unable to manage without intensive assistance and support.
- The activities are designed to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment to preserve or enhance the caregiver's ability to care for the participant in the home.

- Crisis Respite should be included on the POC to the extent that it is an element of the crisis/safety plan or risk mitigation strategy.
- The participant's care team must collaborate to manage the crisis situation and identify subsequent support and service needs.

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for planned and/or crisis relief for the participant or family/primary caregivers to enhance the family/primary caregiver's ability to support the participant's functional, developmental, behavioral health, and/or health care needs and maintain the participant in the home and community.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need to relieve the stressors, assist with reducing disruptions, and maintaining stability within the home to avoid institutionalization through respite at the frequency and duration requested.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation from another involved professional, (i.e., MH professional, pediatrician, school professional etc.) outlining the specific need for respite (break for the caregiver/youth) and the impact on the family tied to a specific outcome, OR
- Documentation from a care manager based upon specific identified assessed needs and or stressors to be relieved that outlines the desired outcome and what efforts will be made to implement other supports or systems to be utilized in the future for the caregivers.

The care manager must maintain documentation regarding other available sources of respite and must maintain documentation barriers accessing other supports, as appropriate, when participant's meet eligibility criteria for other supports (e.g., respite services under the Early Intervention program) and those services are not utilized.

Respite utilization that exceeds the service limits (i.e., annual, daily, monthly), must be necessary to prevent institutionalization and support the child remaining in the home/community, and must be justified by documentation provided by a third-party entity involved in the participant's care. Such documentation may include but is not limited to the documentation types listed above.

Additionally, there must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services*.

Ongoing delivery of Respite is appropriate when:

- The caregiver/ family members continue to need relief/break from caregiving stressors beyond routine childcare, which have been identified in the participant's record.
- Identification of new stressors/goals for continued respite, which have been identified in the participant's record.
- Other sources of respite, such as foster care respite or Early Intervention respite are not available or accessible to the participant.

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services*.

VIII. Prevocational Services

A. Definition

Prevocational Services are individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer work, or career exploration. Prevocational Services are not job-specific but rather are geared toward facilitating success in any work environment for youth whose disabilities do not permit them access to other prevocational services. The service will be reflected in youth's POC/Service Plan and must be directed to teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job productivity requirements.

B. Service Components

Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational Services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and/or capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment.

HCBS providers should have a developed curriculum to provide services, with specific outcomes to be achieved, and approximate timeframes, taking into account the youth's development, particular needs, and condition, to achieve the outcome.

Examples include, but are not limited to:

- Ability to communicate effectively with supervisors, co-workers, and customers.
- Generally accepted community workplace conducts and dress.
- Ability to follow directions.
- Ability to attend to and complete tasks.
- Punctuality and attendance
- Appropriate behaviors in and outside the workplace
- Workplace problem solving skills and strategies.
- Mobility training
- Career planning
- Financial literacy skills
- Proper use of job-related equipment and general workplace safety
- The ability to navigate local transportation options.

Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are

associated with building skills necessary to perform work and optimally to perform competitive, integrated employment, such as the examples listed below:

- Resume writing, interview techniques, role play, and job application completion.
- Exploring career options, facilitating appropriate work habits, acceptable job behaviors, and learning job productivity requirements.
- Assisting in identifying community service opportunities that could lead to paid employment.
- Helping youth to connect their educational plans to future career/vocational goals.
- Helping youth to complete college, technical school, or other applications to continue formal education/training.
- Helping youth to research and apply for financial aid or scholarship opportunities.
- Assisting a participant to understand appropriate work behavior in preparation for obtaining employment including navigating relationships with co-workers, taking directions from a supervisor, professional interactions with customers, etc.
- Activities geared towards teaching how to dress and act professionally.
- Activities geared towards teaching time management skills related to employment.

Documentation is maintained by the care manager that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Note: most participants with disabilities with an IEP are eligible for the Pre-ETS program, which should be utilized prior to accessing Prevocational Services through the Children's Waiver. See the following for additional information: https://www.acces.nysed.gov/vr/pre-ets.

C. Modality

Individual Prevocational Service is provided in-person by 1 staff member to 1 participant

Group Prevocational Service is provided in-person by 1 staff member to up to 3 participants. Participant to staff ratio cannot exceed 3:1.

D. Setting

Refer to *Requirements Applicable to All Services*.

E. Limitations/Exclusions and Utilization

Documentation is maintained by the care manager that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Prevocational services will not be authorized for an HCBS participant if any of the following apply:

- Special education and related services are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA), and the provision of HCBS Prevocational services would be duplicative of such services.
- Vocational rehabilitation services are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR), and the provision of HCBS Prevocational services would be duplicative of such services.
- Vocational services are provided in facility-based work settings that are not integrated in the general community workforce.

Prevocational Services are limited to 2 hours (8 units) per day, 10 hours (40 units) per month, and 120 hours (480 units) per calendar year (all Prevocational combined). However, not all participants will require this level of support. Frequency, scope and duration of the service must be necessary to support the participant remaining in the home or community.

Ages 0 through 13

- Anticipated Utilization: 0 hours (0 units) (all Prevocational combined).

This service is not billable for individuals in this age group.

Ages 14 through 20

- Anticipated Utilization: 0-10 hours (40 units) per month (all Prevocational combined).

At this age, Prevocational services typically involve provision of curriculum-based services geared toward assisting the participant in obtaining employment.

F. Certification/Provider Qualifications

Provider Agency Qualifications

Refer to *Requirements Applicable to All Services*.

Individual Qualifications

Refer to *Requirements Applicable to All Services*.

- **Minimum Qualifications**: An individual with an associate degree and one year of human service experience
- **Preferred Qualifications:** Bachelor's degree with one year of experience in human services working with children/youth.

Supervisor Qualifications

- **Minimum Qualifications**: An individual with a bachelor's degree and three years of experience in human services
- **Preferred Qualifications**: Master's degree with one year of experience in human services working with children/youth.

G. Service Admission Requirements

Refer to *Requirements Applicable to All Services*.

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For Prevocational Services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates the participant's interest and needed support in obtaining skills to assist with volunteer work or paid employment.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need for support in teaching employment related skills at the frequency, scope, and duration requested.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation from another involved professional, (i.e., MH professional, pediatrician, school professional etc.) outlining the specific need, purpose, and desired outcome of the service
- Documentation from a care manager based upon specific identified assessed needs that are outlined and the desired outcome

The service must be outlined in the participant's transition age youth transition plan to support their transition to adult services.

Exceeding the service limits (i.e., annual, daily, monthly) for this service would not be expected.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services*.

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services*.

IX. Supported Employment

A. Definition

Supported Employment services are individually designed to prepare youth (age 14 or older) to engage in paid work. Supported Employment services assist participants in a work setting. Supported Employment provides ongoing supports to participants who, because of their condition which puts them at risk of institutionalization, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Employment services are individualized and may include any combination of the following services:

- vocational/job-related discovery or assessment,
- person-centered employment planning,
- job placement, job development, and negotiation with prospective employers,
- job analysis,
- job carving,
- training and systematic instruction,
- job coaching,
- benefits support,
- training and planning,
- transportation,
- career advancement services, and
- other workplace support services including services not specifically related to job skill training that enable the participant to successfully integrate into the job setting.

Supported Employment services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business.

In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals may also need long term employment support to successfully maintain a job due to the ongoing nature of the HCBS participant's support needs, changes in life situations, or evolving and changing job responsibilities.

B. Service Components

Supported employment services may be provided in a variety of settings, particularly work sites. Supported employment services include the following:

- Supervision and training that are not job-related
- Benefits Education
- Career Exploration (e.g., tours, informational interviews, job shadows)
- Assistance with the development of visual or traditional resumes
- Trial work experiences
- Outreach to prospective employers on behalf of the participant (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the participant; employer needs analysis
- Reemployment services (if necessary due to job loss)
- Intensive ongoing support
- Transportation to and from the job site
- Interface with employers regarding the individual's disability/disabilities and needs related to healthcare issue(s)
- Other activities needed to sustain paid work (e.g., employment assessment, job placement, and/or adaptive/assistive equipment and/or technology necessary for employment)
- Job finding and development training in work behaviors
- Assessing the interest and fit of an individual for particular job opportunities, staff work with employers and job sites preparing them to be able to make necessary and reasonable accommodations
- On-site support for the individual as they learn specific job tasks
- Monitoring through on-site observation and through communication with job supervisors and employers
- Assistance in locating/obtaining needed employment paperwork
- Assisting the participant in advocating for their needs at a job placement

C. Modality

Individual Supported Employment is provided in-person by 1 staff member to the participant and/or the participant's employer.

D. Setting

Refer to *Requirements Applicable to All Services*.

E. Limitations/Exclusions and Utilization

Refer to *Requirements Applicable to All Services*.

Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

Supported Employment service is not allowed for an HCBS participant if any of the following apply:

- Special education and related services are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA), and the provision of Supported Employment would be duplicative of such services.
- Vocational rehabilitation services are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, and the provision of Supported Employment would be duplicative of such services.
- Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
- Supported employment does not include payment for supervision, training, support, and/or adaptations typically available to other workers without disabilities filling similar positions in the business.
- Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through Prevocational services.

Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment
- Payments that are passed through to users of Supported Employment services

Supported Employment is limited to 3 hours (12 units) per day (all Supported Employment combined), 10 hours (40 units) per month (all Supported Employment combined), and 120 hours (480 units) per calendar year (all Supported Employment combined). However, not all participants will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

Ages 0 through 13

- Anticipated Utilization: 0 hours (0 units).

This service is not billable for individuals in this age group.

Ages 14 through 20

- Anticipated Utilization: 0-10 hours (40 units) per month.

At this age, Supported Employment services typically involve provision of curriculum-based services geared towards assisting the participant in obtaining or retaining employment.

F. Certification/Provider Qualifications

Provider Agency Qualifications

Refer to *Requirements Applicable to All Services*.

Individual Qualifications

Refer to *Requirements Applicable to All Services*.

- **Minimum Qualifications**: An individual with an associate degree and one year of human service experience
- **Preferred Qualifications**: Bachelor's degree with one year of experience in human services working with children/youth.

Supervisor Qualifications

- **Minimum Qualifications:** An individual with a bachelor's degree and three years of experience in human services
- **Preferred Qualifications:** Master's degree with one year of experience in human services working with children/youth.

G. Service Admission Requirements

Refer to Requirements Applicable to All Services

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for intensive on-going supports, as a result of their condition which puts them at risk of institutionalization, to obtain and maintain employment.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need for intensive on-going support, at the frequency, scope, and duration requested, to obtain and maintain employment.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation from another involved professional, (i.e., MH professional, pediatrician, school professional etc.) outlining the specific need, purpose, and desired outcome of the service
- Documentation from the care manager regarding the specific need for support, desired career goals, and goal to be achieved.

Exceeding the service limits (i.e., annual, daily, monthly) for this service would not be expected.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services*.

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services*.

X. Palliative Care Suite of Services

Palliative Care is specialized medical care focused on providing relief from the symptoms and stress of a chronic medical condition or illness. The goal of Palliative Care services is to improve quality of life for both the participant and the family. It is appropriate at any stage of a chronic condition or illness (unless otherwise noted) and can be provided along with curative treatment.

XI. Palliative Care – Expressive Therapy

A. Definition

Expressive Therapy (art, music, and play) helps participants better understand and express their reactions through creative and kinesthetic treatment. Expressive therapy helps participants to feel empowered in their own creativity, control, and aid in their communication of their feelings when their life and body may be rapidly changing during the stressful time of undergoing a chronic medical condition or illness and the trauma that often comes with its treatment. Whether through music, art, and/or play therapy, the participant may find an outlet that allows them to express their emotions safely and have a medium where they have complete control to play and explore with abandon. The family can participate as well, whether in the form of memories shared together or by tangible objects made by the participant they can hold onto - scrapbooks, paintings, or sculpture - mementos that tell their participant's life from their perspective and aid in their family's own journey of grief and loss.

B. Service Components

Expressive Therapy (art, music and play) helps the participant better understand and express their feelings, emotions, behaviors, etc. through creative and kinesthetic treatment. Utilizing various modalities (art, music, etc.) for the participant to express themselves, communicate with others surrounding difficult topics and or feelings.

Examples

- Engaging the participant/family in activities that foster opportunities to reflect, share memories, and build connection (i.e. sharing and discussing family pictures).
- Listening to or making music or art to assist with processing emotions connected to the participant's condition.

C. Modality

Individual Expressive Therapy is provided in-person by 1 staff member to the participant and/or the participant's family. The Children's Waiver participant must be present when this service is provided to the family.

D. Setting

Refer to *Requirements Applicable to All Services*.

E. Limitations/Exclusions and Utilization

Refer to *Requirements Applicable to All Services*.

Expressive Therapy is limited to the lesser of (4 hours/16 units) per month or 48 hours (192 units) per calendar year. However, not all participants/families will require this level of support. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

Specific interventions steps must be identified and should be treatment-based. The participant's age, development, and condition should also be taken into consideration. The need for this service may change throughout the progression of the participant's condition. It is the responsibility of the HCBS provider, in collaboration with the care manager, to adjust service delivery appropriately to meet the need of the participant based on their conditions and circumstances.

F. Certification/Provider Qualifications

Refer to *Requirements Applicable to All Services*.

Provider Agency Qualifications

Refer to *Requirements Applicable to All Services*.

Individual Staff Qualifications

Refer to *Requirements Applicable to All Services*.

Minimum Qualifications

- An individual with a minimum of one year of experience working with the medically fragile population, preferably involving palliative care.
- Child Life Specialist with certification through the Child Life Council; Creative Arts Therapist licensed by the State of New York; Music Therapist with a bachelor's degree from a program recognized by the NYS Education Department; Play Therapist with a Master's Degree from a program recognized by the New York State Education Department; current Play Therapist Registration conferred by the Association for Play Therapy (Expressive Therapy (Art, Music, and Play))
- Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the

supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider.

G. Service Admission Requirements

Refer to *Requirements Applicable to All Services*.

Expressive Therapy may be provided when the following criteria are met:

- The need for an expressive outlet for the participant/family to process and understand the participant's chronic medical condition or illness has been assessed, determined, and authorized as part of the person-centered planning process.
- Expressive Therapy is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) related to processing of the participant's chronic medical condition or illness.
- The activities support the participant/family's ability to express their reactions to the participant's chronic medical condition or illness, the associated stress of such a condition, and/or the trauma associated with treatment for the condition.

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For services provided within the Initial Service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for the participant/family to express their reactions and emotions related to the participant's chronic medical condition or illness through Expressive Therapy.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need for an expressive outlet for the participant/family to process and understand the participant's chronic medical condition or illness. The treatment modality (art, music, etc.), and the frequency and duration requested must be clearly indicated in the documentation.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation of the participant's specific chronic medical/illness treatment needs and symptoms
- Documentation from another involved professional ((i.e., MH professional, pediatrician, licensed specialist, school professional etc.) outlining the specific expressive needs tied to the participant's chronic medical condition or illness and specific desired outcome

- Documentation from a care manager based upon specific identified assessed needs that are outlined and the desired outcome

Service utilization that exceeds the service limits (i.e., annual, daily, monthly), must be necessary to prevent institutionalization and support the child remaining in the home/community, and must be justified by documentation provided by a third-party entity involved in the participant's care. Such documentation may include but is not limited to the documentation types listed above.

Additionally, there must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services*.

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services*.

XII. Palliative Care – Massage Therapy

A. Definition

Massage Therapy: To improve muscle tone, circulation, range of motion, and address physical symptoms related to illness as well as provide physical and emotional comfort, pain management, and restore the idea of healthy touch for participants who are dealing with treatments that may involve painful interventions and ongoing and/or past medical trauma.

B. Service Components

Massage Therapy is provided to improve muscle tone, circulation, range of motion and address physical symptoms related to their chronic medical condition or illness.

Examples

- Teach the participant exercises to reduce pain and address chronic diseases.
- Provide pain relief, promote healing through provision of massage therapy applied to impacted areas of the body.
- Teach techniques to improve circulation and range of motion to address physical symptoms from a chronic medical condition or illness.

C. Modality

Individual Massage Therapy is provided in-person by 1 staff member to 1 participant.

D. Setting

Refer to *Requirements Applicable to All Services*.

E. Limitations/Exclusions and Utilization

Refer to *Requirements Applicable to All Services*.

Massage Therapy service is limited to 1.5 hours (6 units) per month or 18 hours (72 units) per calendar year. However, not all participants/families will require this level of support. Frequency, scope and duration of the service must be necessary to support the participant remaining in the home or community.

It is expected that utilization may change throughout the progression of the participant's condition. It is the responsibility of the HCBS provider, in collaboration with the care manager to adjust service delivery appropriately to meet the need of the participant based on their conditions and circumstances.

F. Certification/Provider Qualifications

Provider Agency Qualifications

Refer to *Requirements Applicable to All Services*.

Individual Staff Qualifications

Refer to *Requirements Applicable to All Services*.

Minimum Qualifications:

- Massage therapist currently licensed by the State of New York
- An individual with a minimum of one year working with the medically fragile population, preferably involving palliative care.

G. Service Admission Requirements

Refer to *Requirements Applicable to All Services*.

Massage Therapy may be provided when the following criteria are met:

- The need to improve the participant's muscle tone, circulation, range of motion and address physical symptoms related to their chronic medical condition or illness has been assessed, determined, and authorized as part of the person-centered planning process.
- Massage Therapy is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) to enhance the participant's muscle tone, circulation, or range of motion and/or address physical symptoms related to their chronic medical condition or illness.
- The activities support enhancement of the participant's muscle tone, circulation, or range of motion and/or address physical symptoms related to their chronic medical condition or illness.

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for supporting the enhancement of the participant's muscle tone, circulation, or range of motion and/or addressing physical symptoms related to their chronic medical condition or illness through Massage Therapy.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and

maintained in the participant's record that indicates an assessed need for enhancement of the participant's muscle tone, circulation, or range of motion and/or need to address physical symptoms related to the participant's chronic medical condition or illness through massage therapy at the frequency, scope, and duration requested.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation of the participant's specific chronic medical/illness treatment needs and symptoms
- Documentation from another involved professional outlining the specific Massage Therapy needs tied to a specific outcome, (i.e., pediatrician, licensed medical specialist, etc.)
- Documentation from a care manager based upon specific identified assessed needs that are outlined and the desired outcome.

Service utilization that exceeds the service limits (i.e., annual, daily, monthly), must be necessary to prevent institutionalization and support the child remaining in the home/community, and must be justified by documentation provided by a third-party entity involved in the participant's care. Such documentation may include but is not limited to the documentation types listed above.

Additionally, there must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services*.

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services*.

XIII. Palliative Care- Counseling and Support Services

A. Definition

Counseling and Support Services provide help for participants and their families to cope with grief related to the participant's chronic medical condition or illness. Participants with a chronic medical condition or illness and their families cope with grief and loss in a variety of ways and may need various kinds of support over time, including counseling, support groups, and other services. Counseling and Support Services can be provided to participants who are receiving services with a hospice care provider, if the services are not duplicative.

Further information regarding Counseling and Support Services, including the additional month of care management and post-mortem counseling and support can be found in the Palliative Care – Bereavement Services and Health Home Care Management policy.

Note: These services can be offered at any point after a Children's Waiver participant is diagnosed with a chronic medical condition or illness.

Palliative Care Counseling and Support Services can be delivered:

1. To the participant with a chronic medical condition or illness and the participant's identified family members prior to the passing of the participant,

AND/OR

2. To the participant's identified family after the passing of participant, if the HCBS provider's Service Plan and the care manager's plan of care (POC) denotes the service as outlined below.

B. Service Components

Counseling and Support Services provides help for participants and their families to cope with the participant's chronic medical condition or illness, and with grief/loss related to the participant's passing.

Examples

- Grief counseling for the participant and/or their families
- Support groups for the participant and/or their families.
- Counseling to the family and or participant to understand the chronic medical condition or illness.
- Family and or participant to be able to discuss their chronic/life threatening condition, manage their feelings/emotions, and future planning

C. Modality

Individual Counseling and Support Service is provided in-person by 1 staff member to 1 participant and/or the participant's family. This service can be provided directly to the participant, to the family with the participant present, or to the family without the participant present.

Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the child/youth, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

D. Setting

Refer to *Requirements Applicable to All Services*.

E. Limitations/Exclusions and Utilization

Refer to *Requirements Applicable to All Services*.

When Counseling and Support Services are provided prior to the passing of an HCBS participant, frequency, scope and duration of the service must be necessary to support the participant remaining in the home or community. When provided during the participant's lifetime, this service is limited to five 5 hours (10 Units) per month or 60 hours (120 Units) per calendar year.

When provided after the participant passes, counseling and support can be provided to the family for up to six months after the participant's passing. Health Home care management can be provided for up to one month after the participant has passed. However, not all participants/families will require this level of support. Frequency, scope and duration of the service must be necessary to support the participant remaining in the home or community.

Anticipated Utilization: 0-5 hours (10 units) per month.

Counseling and Support services typically involves a specific identified need and specific intervention steps. The service must be used as described and not in lieu of another, more appropriate service.

Age and development must be taken into consideration when serving the participant.

It is expected that utilization may change throughout the progression of the participant's condition. It is the responsibility of the HCBS provider, in collaboration with the care

manager to adjust service delivery appropriately to meet the need of the participant based on their conditions and circumstances.

F. Certification/Provider Qualifications

Refer to *Requirements Applicable to All Services*.

Provider Agency Qualifications

Refer to *Requirements Applicable to All Services*.

Individual Staff Qualifications

Refer to *Requirements Applicable to All Services*.

Minimum Qualifications:

- An individual with a minimum of one year working with the medically fragile population, preferably involving palliative care.
- Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Psychologist, Licensed Mental Health Counselor (LMHC), or Licensed Creative Arts Therapist (LCAT) that meet current NYS licensing guidelines.
- Student interns practicing within the scope of the New York State Education law and supervised by a licensed practitioner in that profession can deliver HCBS; student interns and limited permittees can treat Medicaid enrollees under the supervision of a licensed practitioners in that profession who must be enrolled as a Medicaid provider.

G. Service Admission Requirements

Refer to *Requirements Applicable to All Services*.

The Palliative Care Counseling and Support Services provider must conduct an initial review to determine the needs of the participant and their family. This review should be incorporated into the provider's Service Plan that outlines the frequency, scope, and duration of counseling to be provided, *and* that service plan should be incorporated into the HCBS care management POC. For families to receive six (6) months of Counseling and Support Services after the passing of their participant the service must be included in the POC prior to or at the time of the participant's passing. The family can also receive one (1) additional month of Health Home care management, and these needs should be incorporated in the POC. The additional six (months) of counseling and extra month of care management doesn't need Medicaid Managed Care Plan authorization, as this is a continuation of services for the family from the services that were already being provided prior to the passing of the participant.

Counseling and Support Services may be provided when the following criteria are met:

- The need for assistance in coping with grief related to the participant's chronic medical condition or illness has been assessed, determined, and authorized as part of the person-centered planning process.
- Counseling and Support Services is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) related to assisting participants and their families to cope with grief related to the participant's chronic medical condition or illness
- The activities support the participant/family's ability to cope with grief related to the participant's chronic medical condition or illness. Family members who will receive these supports should be identified in the POC.

Counseling and Support Services provided by the HCBS provider can be provided after the participant's passing when the following criteria are met:

- Waiver participant has passed away from a chronic medical condition or illness and their family needs assistance to cope with the grief related to the loss of the participant through continued Counseling and Support Services
- Prior to the participant's passing, the Palliative Care Counseling and Support Services provider conducted an initial review (as described above) to determine the counseling and support needs of the participant and their family, which included a need for ongoing counseling and support services after the participant's passing.

The Bereavement component of Counseling Support Services provided by the Care Manager (1 additional month of care management) can be provided when the following criteria are met:

- Waiver participant has passed away and their family needs an additional month of care management services to assist with organizing and coordinating care related to the participant's passing (i.e. coordinating return of medical equipment, terminating Private Duty Nursing, ending medical supply deliveries, etc.).
- Prior to the participant's passing, the Palliative Care Counseling and Support Services provider conducted an initial **review (as** described above) to determine the counseling and support needs of the participant and their family, which included a need for ongoing counseling and support services after the participant's passing.

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for assistance with coping with grief related to the participant's chronic medical condition or illness.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need for support processing grief related to the participant's chronic medical condition or illness at the frequency, scope, and duration requested.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation of the participant's specific chronic medical/illness treatment needs and symptoms
- Documentation from another involved professional (i.e., pediatrician, licensed medical specialist, etc.) outlining the specific Counseling and Support needs tied to a specific outcome
- Documentation from a care manager based upon specific identified assessed needs that are outlined and the desired outcome.

Service utilization that exceeds the service limits (i.e., annual, daily, monthly), must be necessary to prevent institutionalization and support the child remaining in the home/community, and must be justified by documentation provided by a third-party entity involved in the participant's care. Such documentation may include but is not limited to the documentation types listed above.

Additionally, there must be documentation in the case record that the multidisciplinary care team has determined a need for HCBS in excess of the service limits to prevent institutionalization, determined whether other services are appropriate, and has established a plan to monitor the participant's progress.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services*.

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services*.

When provided after the passing of a participant, this service is time limited. If the family continues to require additional support beyond 1 month of care management/up to 6 months of Counseling and Support Services, the provider/care manager should assist the family with discharge planning and making connections to other available resources, to the extent possible

XIV. Palliative Care – Pain and Symptom Management

A. Definition

Pain and Symptom Management is relief and/or control of the participant's suffering related to their chronic medical condition or illness.

Pain and Symptom Management is an important part of aiding in providing relief from pain and symptoms and/or controlling pain, symptoms, and side effects related to chronic medical condition or illness a participant is enduring. This management is not only an important part of humanely caring for the participant's pain and suffering but helping the participant and family cope and preserve their quality of life at a difficult time.

B. Service Components

Pain and Symptom Management is relief and/or control of the participant's suffering related to their chronic medical condition or illness.

Examples

- Teaching the participant how to navigate and use pain medications in a safe and effective way.
- Assist the participant with tracking physical warning signs before symptoms persist.
- Assist the participant with monitoring symptoms to find patterns of worsening/improving symptoms.
- Helping caregivers understand how to assist the participant with their symptoms and pain, when to seek additional assistance with management of condition and pain.

C. Modality

Individual Pain and Symptom Management is provided in-person by 1 staff member to 1 participant.

D. Setting

Refer to *Requirements Applicable to All Services*.

E. Limitations/Exclusions and Utilization

Refer to *Requirements Applicable to All Services*.

Pain and Symptom Management is not limited to a specified number of hours/units per day, month, or calendar year. Frequency, scope, and duration of the service must be necessary to support the participant remaining in the home or community.

It is expected that utilization may change throughout the progression of the participant's condition. It is the responsibility of the HCBS provider, in collaboration with the care manager to adjust service delivery appropriately to meet the need of the participant based on their conditions and circumstances.

F. Certification/Provider Qualifications

Provider Agency Qualifications

Refer to *Requirements Applicable to All Services*.

The agency must be a Certified Home Health Agency (CHHA), Hospice Organization, or Article 28 Clinic.

Individual Staff Qualifications

Refer to *Requirements Applicable to All Services*.

Minimum Qualifications:

- An individual with a minimum of one year working with the medically fragile population, preferably involving palliative care.
- Pediatrician or Family Medicine Physician board certified in Pediatrics or Family Medicine licensed by the State of New York;
- Nurse Practitioner licensed by the State of New York (Pain and Symptom Management);
- Registered Nurse licensed by the State of New York under the direct supervision of a pediatrician or medical physician, board certified in Pediatrics.

G. Service Admission Requirements

Refer to *Requirements Applicable to All Services*.

Pain and Symptom Management may be provided when the following criteria are met:

- The need for relief and/or control of the participant's suffering related to their chronic medical condition or illness has been assessed, determined, and authorized as part of the person-centered planning process.
- Pain and Symptom Management is identified in the participant's Service Plan and Plan of Care and is associated with specific attainable goal(s)/outcome(s) related to relief and/or control of the participant's suffering related to their chronic medical condition or illness.

- The activities support the relief and/or control of the participant's suffering related to their chronic medical condition or illness.

H. Service Necessity Documentation

Refer to *Requirements Applicable to All Services*.

For services provided within the initial service period, the participant must have an adequate and complete referral from an HHCM/C-YES which clearly indicates a need for Pain and Symptom Management services.

Services provided beyond the initial service period must be supported by clear documentation of a thorough assessment completed by the HCBS provider and maintained in the participant's record, that indicates an assessed need for relief and/or control of the participant's suffering related to their chronic medical condition or illness at the frequency, scope, and duration requested.

If a comprehensive evaluation/assessment lacks relevant details or adequate justification, additional documentation may be required, as outlined below:

- Documentation of the participant's specific chronic medical/illness treatment needs and symptoms
- Documentation from another involved professional (i.e, pediatrician, licensed medical specialist, etc.) outlining the specific Pain and Symptom Management needs tied to a specific outcome.
- Documentation from a care manager based upon specific identified assessed needs that are outlined and the desired outcome.

I. Continued Stay Criteria

Refer to *Requirements Applicable to All Services*.

J. Service Discharge Criteria

Refer to *Requirements Applicable to All Services*.

Appendix A: Allowable Settings Chart

Children's Waiver Home and Community-Based Services (HCBS) are required to be offered in the least restrictive setting for the desired outcomes, including the most integrated home or other community-based settings where the participant lives, works, engages in services, and/or socializes. It also includes settings in the family and caregiver network. Family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Allowable settings in compliance with Medicaid regulations and the Home and Community Based Settings Final Rule (§441.301(c)(4) and §441.710) (HCBS Manual see Appendix B) will exhibit characteristics and qualities most often articulated by the individual participant and family/caregiver as key determinants of independence and community integration.

Excluded Settings:

Services cannot be provided in an ineligible setting, including but not limited to:

- A hospital,
- Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD),
- Psychiatric Residential Treatment Facility (RTF),
- Skilled nursing facility,
- New York State Office for People with Developmental Disabilities (OPWDD) -certified residences, social day care or healthcare setting in which employees of the setting care for or provide supervision of the participant,
- Office of Children and Family Services (OCFS) Licensed Institutions -defined in New York State Social Services Law regulation 18 NYCRR 427.2(f) as a facility established for the 24-hour care and maintenance of 13 or more children and operated by a childcare agency (Voluntary Foster Care Agency).
- Other institutional setting, according to the HCBS Settings Rule

The HCBS provider is responsible for ensuring that all service provision meets standards outlined in the HCBS Final Rule Compliance Policy. It is the responsibility of the Care Manager to monitor participant placement, notify care team members of updates, and initiate Waiver disenrollment as necessary.

Excluded Participants:

HCBS cannot be billed for participants who are residing/admitted to an ineligible setting, regardless of the setting in which the service is provided, including but not limited to:

- A hospital,
- Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD),
- Psychiatric Residential Treatment Facility (RTF),
- Skilled nursing facility,
- Residential programs that provide services that duplicate HCBS

Refer to the below chart for additional information on service provision to participants who reside in various settings.

HCBS Delivery/Enrollment Restrictions by Setting

Type Of Setting/Facility	HCBS May be Provided to the Member Off-Site (Yes/No)*	HCBS May be Provided On-Site (Yes/No)**
OCFS Programs		
VFCA Foster Boarding Home	Yes	Yes
VFCA Group Home (GH), Agency Operated Boarding Home (AOBH), Supervised Independent Living Program (SLIP)[1]	Yes	Yes
VFCA Group Residence/ Institution	No	No
OMH Programs		
OMH Licensed Crisis Residential Program[2]	Yes	Yes
OMH Licensed Children's Community Residence	No	No
OMH Licensed Adult Community Residence	Yes	No
OMH Licensed Psychiatric Residential Treatment Facility (RTF)	No	No
OMH Comprehensive Psychiatric Emergency Programs (CPEP)	No	No
OMH Operated Psychiatric Hospital Inpatient	No	No
OASAS Programs		
OASAS-Licensed Residential Rehabilitation Services for Youth	No	No
OPWDD Programs		
OPWDD Intermediate Care Facility (ICF)	No	No
OPWDD Developmental Center (DC)	No	No
OPWDD Children's Residential Project (CRP)	No	No
OPWDD Extended Treatment (ETU) and Comprehensive Adult Transitional (CATH) Units	No	No
OPWDD Group Homes (Residential Habilitation) (Supervised IRA and Family Care Homes)	No	No
DOH Programs		
General Hospital	No	No
Nursing Home	No	No
Other Programs		
Private Psychiatric Hospitals	No	No

*Wherever HCBS can be provided off-site, it is permissible for the participant to be enrolled in HCBS. Wherever it is not permissible to provide services off-site, HCBS enrollment is not permissible.

***Settings listed as being allowable for on-site service provision must meet HCBS Settings Final Rule requirements. Exceptions exist for Respite services.*