To ensure OAAS waiver participants receive the most appropriate services and care management under managed care, any individual with intellectual and developmental disabilities (I/DD) who is receiving OAAS Community Choice Wavier (CCW) services will be transitioned to the Residential Options Waiver (ROW)

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by the number of individuals with intellectual and developmental disabilities (I/DD) who are receiving Community Choice and or Adult Day Health Care support via Office of Adult and Aging Services who are expected to transition to the ROW beginning July 1, 2015.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	205
Year 3	10
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Persons who need HCBS due to a crisis situation

Purpose *(describe):*

To provide for the emergency health and safety needs of persons in a crisis situation who meet the ICF/DD level of care when waiver services are necessary to avoid institutionalization.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on analysis of emergency need situations involving requests for waiver or ICF/DD services.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	45
Year 2	80
Year 3	105
Year 4	130
Year 5	144

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Persons Transitioning from Supports and Services Centers to HCBS

Purpose *(describe):*

ROW opportunities will be available to residents residing at Supports and Service Centers. Residents will have the opportunity to choose to transition from a Supports and Service Center into home and community based services.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by estimating the number of Supports and Service Center residents who wish to transition to HCBS services.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	45
Year 2	50
Year 3	60
Year 4	90
Year 5	100

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Persons voluntarily transitioning from ICFs/DD to HCBS based on their RSFR protected date

Purpose *(describe):*

Provide ROW opportunities to persons residing in ICFs/DD who are on the Request for Services Registry. Providing ROW opportunities to these individuals will assist in reducing the overall number of people residing in ICFs/DD who have expressed an interest in receiving HCBS.

Describe how the amount of reserved capacity was determined:

The amount of the reserved capacity is based on the number of persons residing in private ICFs/DD who have expressed an interest in transitioning to home and community based services.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	75
Year 2	115
Year 3	130
Year 4	150
Year 5	170

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Persons voluntarily transitioning from ICFs/DD to HCBS through conversion

Purpose *(describe):*

Provide ROW opportunities to persons who meet the ICF/DD level of care and who wish to receive waiver services. This group includes persons whose existing ICF/DD funding/rates can fully fund their transition to a ROW residential setting through voluntary ICF/DD conversion.

Describe how the amount of reserved capacity was determined:

The amount of the reserved capacity is based on the statewide stakeholder meetings which have been conducted with ICF/DD residents, residents' families, and providers. These providers have indicated a potential interest in converting their ICFs/DD into ROW opportunities for the residents of the ICF/DD.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	20
Year 2	30

Waiver Year	Capacity Reserved
Year 3	60
Year 4	70
Year 5	100

Appendix B: Participant Access and Eligibility

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

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

- (•) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (•) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

The rule for the ROW published in the Louisiana Register, Volume 37 No. 12, December 20, 2011 specifies the groups identified for selection into this waiver.

The following categories of individuals from the MR/DD target group will be awarded ROW opportunities:

- Persons who meet the ICF/DD level of care and who need HCBS due to a health and/or safety crises situation (crisis diversion)
- Children (including birth through age 18) in NFs requiring high-need rates who wish to transition to HCBS residential services and who meet the level of care that qualifies them for ROW eligibility who participate in the MFP
- Adults and children in Nursing Facilities (NFs) who wish to transition to HCBS residential services and who meet the level of care (LOC) that qualifies them for ROW eligibility based on their Request for Services Registry (RFSR) protected date
- Persons residing in ICFs/DD who wish to transition to a HCBS residential service setting through a voluntary conversion opportunity
- Persons residing in ICFs/DD who wish to transition to a HCBS residential service setting and are eligible based on their Request for Services Registry (RFSR) protected date
- Persons transitioning from Supports and Services Centers into home and community based services

Participants with OCDD Statement of Approval and who formerly received OAAS Community Choice Wavier (CCW) and or Adult Day Health Care (ADHC) services transitioning to the ROW

BHSF/WCS and OCDD have the responsibility to monitor the utilization of the ROW opportunities. At the discretion of BHSF and OCDD, specifically allocated waiver opportunities may be reallocated to better meet the needs of citizens with developmental disabilities in the State of Louisiana.

BHSF/WCS and OCDD reviews slot allocation data to determine if there is any under-utilization or anticipated over-utilization in the waiver slots reserved for priority groups. During this process, stakeholder input is utilized to make policy revisions to ensure the equitable and fair allocation of waiver slots. In addition, public input is solicited during the State's rulemaking process (as enacted through R.S. 49:951 et seq. Act No. 775 §1, effective June 30, 2010 of the 2010 Regular Legislative Session). BHSF/WCS will submit an amendment to the waiver, as necessary, to denote changes to the waiver slot allocations.

Medicaid's data contractor has responsibility for maintenance of the Request for Services Registry (RFSR) and for slot offers according to policy as written in B-3-f. BHSF/WCS has oversight of the data contractor's role in maintaining the registry according to that policy. In addition, bi-weekly meetings are held between the Medicaid data contractor, OCDD, and BHSF/WCS to review and to assure adherence to these regulations along with equitability and fairness in slot allocations and distributions.

The State Medicaid Agency retains ultimate administrative authority and oversight for all Medicaid waiver programs. OCDD is required to provide State Medicaid Agency with all rulemaking, policy, proposed changes and waiver amendments prior to implementation.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

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

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

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

  Select one:

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

  Specify percentage: _____

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

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

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

Check each that applies:

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

  Select one:

  - **300% of the SSI Federal Benefit Rate (FBR)**
  - **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

    Specify percentage: _____
  - **A dollar amount which is lower than 300%.**

    Specify dollar amount: _____
- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

  Select one:

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

    Specify percentage amount: _____
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  Medically needy with spend down to or below the medically needy income standard using the state average monthly Medicaid rate for residents of Intermediate Care Facilities/Developmental Disability and other incurred expenses to reduce an individual's income.

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
  Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

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

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage: _____

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

Specify dollar amount: _____

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

Specify percentage: _____

○ **Other standard included under the State Plan**

Specify:

_____

○ **The following dollar amount**

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

The following formula is used to determine the needs allowance:

Specify:

_____

○ **Other**

Specify:

_____

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

Not Applicable (see instructions)
SSI standard
Optional State supplement standard
Medically needy income standard
The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

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

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
The State does not establish reasonable limits.
The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

---

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

The Level of Care evaluation and re-evaluation is completed by a Medical Certification Specialist 1 or 2 and/or a Health Standards Certification Specialist 1 or 2.

The basic qualifications for the Health Standards Certification Specialist 1 (HSCS-1) are as follows:

A baccalaureate degree plus three years of professional level experience in hospital or nursing home administration, public health administration, social services, nursing, pharmacy, dietetics/nutrition, physical therapy, occupational therapy, or medical technology or in related professions in the health and social care industries. Eight years of full-time work experience in any field may be substituted for the required baccalaureate degree.

The HSCS-2 must be followed by one additional year of professional experience in the qualifying fields, or surveying health or social service programs or facilities for compliance with state and federal regulations.

The basic qualifications of the Medical Certification Specialist 1 (MCS-1) are as follows:

A baccalaureate degree plus three years of professional level experience in nursing, pharmacy, dietetics/nutrition, physical therapy, occupational therapy, or medical technology, or surveying health or social service programs or facilities for compliance with state and federal regulations. A current valid Louisiana license in one of the qualifying fields will substitute for the required baccalaureate degree. A master's degree in one of the qualifying fields will substitute for a maximum of one year of the required experience.

The MCS-2 must be followed by four years of professional level experience, rather than the three years of professional experience.

All activities are supervised by individuals with education, experience, and training in the diagnosis of MR/DD.

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

The level of care criteria is based upon the following:

La. R.S. 28:451.2. Definitions:

"...(12) Developmental Disability means either:

(a) A severe chronic disability of a person that:

(i) Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.

(ii) Is manifested before the person reaches age twenty-two.

(iii) Is likely to continue indefinitely.

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

(aa) Self-care

(bb) Receptive and expressive language.

(cc) Learning.

(dd) Mobility.

(ee) Self-direction.

(ff) Capacity for independent living.

(gg) Economic self-sufficiency.

(v) Is not attributed solely to mental illness.

(vi) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

(b) A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria in Subparagraph (a) of this Paragraph, later in life that may be considered to be a developmental disability."

The Medicaid Bureau of Health Services Financing (BHSF) form 90-L is used to determine the ICF/DD Level of Care. The individual's primary care physician must complete and sign and date the 90-L. This form must be completed at initial evaluation and annually thereafter to determine if the individual still meets the ICF/DD level of care. The 90-L is used in conjunction with the Statement of Approval (SOA) to establish a level of care criteria and to complete the Plan of Care. SOA is a notification to an individual who has requested waiver services that it has been determined by the OCDD or Human Services Authorities or Districts that they meet the developmental disability criteria (Developmental Disability Law- La. R.S. 28:451) for participation in programs administered by OCDD and that they have been placed on the Request for Services Registry for waiver services and their protected date of request. The 90-L, SOA and plan of care documents are submitted by the Support Coordination Agency to the OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts for staff review to assure that the applicant/participant meets/continues to meet the level of care criteria.

The Developmental Disability (DD) decision is made by the OCDD Regional Waiver Supports and Services Office or Human Services Authorities or Districts utilizing the systems entry process. If the individual is determined to meet the DD criteria they are issued a Statement of Approval (SOA), if they do not meet the DD criteria they are issued a Statement of Denial (SOD). Individuals who receive a SOD are informed of their rights to appeal and are provided information regarding the appeals process. Please refer to Fair Hearings/Appeals process as outlined in Appendix F-section F-1 of the waiver document.

The OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff conduct a pre-certification home visit to verify accuracy of level of care for all initial evaluations only.

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

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

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

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

The Medicaid Bureau of Health Services Financing (BHSF) form 90-L is used to determine the ICF/DD Level of Care. The individual's primary care physician must complete and sign and date the 90-L. This form must be completed at initial evaluation and annually thereafter to determine if the individual still meets the ICF/DD level of care. The 90-L is used in conjunction with the Statement of Approval to establish a level of care criteria and to complete the Plan of Care. The 90-L, Statement of Approval and Plan of Care documents are submitted to the OCDD Regional Waiver Supports and Services Office or Human Services Authoritiy or District for staff review to assure that the applicant/participant meets/continues to meet the level of care criteria. The OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff conducts a pre-certification home visit to verify accuracy of level of care for all initial evaluations.

There is no difference in the process for the LOC evaluations and re-evaluations. Level of Care evaluations are conducted at least annually.

The Developmental Disability decision is made by the OCDD Regional Waiver Supports and Services Office or Human Services Authorities or Districts utilizing the systems entry process. If the individual is determined to meet the DD criteria they are issued a Statement of Approval, if they do not meet the DD criteria they are issued a Statement of Denial (SOD). Individuals who receive a SOD are informed of their rights to appeal and are provided information regarding the appeals process. Please refer to Fair Hearings/Appeals process as outlined in Appendix F-section F-1 of the waiver document.

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

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

Specify the other schedule:

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

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

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

The Medicaid Data Contractor has edits in the database system for tracking to ensure timely re-evaluations for the level of care.

When the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District sends an approved Plan of Care to the Medicaid data contractor, the information contains the date of the 90L (date of the physician's signature). This date is tracked in the data contractor's database for every Plan of Care. The 90L date is compared to the Plan of Care begin date to determine if the reevaluation was performed timely. The database generates a report which is shared with both OCDD or Human Services Authorities or Districts and BHSF.

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

Records of level of care are maintained by the OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts and in the physical office of the Support Coordination Agency.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
B.a.i.a.1. Number and percentage of waiver applicants who have been determined to meet the ICF/DD level of care prior to waiver certification. Percentage = Number of applicants in the sample who were determined to have met the level of care determination criteria /Number of applicants reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
B.a.i.b.1. Number and percentage of waiver participants who received a level of care re-evaluation within 12 months of their initial or annual evaluation. Percentage = Number of waiver participants who received a timely level of care re-evaluation / Total number of waiver participants due for a re-evaluation reviewed in the sample.

Data Source (Select one):

Other
If 'Other' is selected, specify:
LOC/LOC Database

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data i

analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.a.i.c.1. Number and percentage of applicants/participants who's LOC has been completed following state procedures. Percentage = Number of levels of care completed according to state procedures/Total number of waiver partiicpants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

A variety of mechanisms are employed by WCS to ensure all issues with the operating agency/contractor's performance were remediated:

1. WCS meets with the contractors and operating agency staff on an as needed basis but no less than quarterly to discuss delegated functions, pending issues, and remediation plans. Individual issues requireming remediation will be referred back to the operating agency and/or contractor for correction. WCS will monitor to ensure remediation activities were completed to address any identified areas of non-compliance within 30 days of notification. Systemic issues requiring remediation will be identified and discussed at the Cross Waiver (which includes staff from WCS, OAAS, and OCDD) Review Team Commitee meetings. A plan for remediation and persons responsible will be developed for each identified item. Remediation strategies and progress towards correction will be reviewed and documented at the next scheduled meeting.

2.WCS, the Medicaid Director or Deputy Director, the OCDD Assistant Secretary, and other pertinent staff meet on at least a quarterly basis to discuss any pending issues and remediation plans.

3. Memorandums are sent from BHSF to OCDD to ensure all necessary leadership is informed of the support actions neede to correct problems or make improvements.

ii. **Remediation Data Aggregation**

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

ppendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are

employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The OCDD currently utilizes the "Case Management Choice and Release of Information Form" to provide a means for the person to state that they understand their choice between institutional and HCBS and the alternatives under the waiver. The information is also reviewed with the participant and/or authorized representative at a pre-certification home visit conducted by the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff prior to approval of the initial Plan of Care. The Support Coordinator offers the choice between institutional and HCBS, annually thereafter.

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

The forms are maintained in the records at the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District and the physical office of the Support Coordination Agency.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
A language service vendor, Certified Languages International, under contract with DHH, the single state Medicaid Agency. All forms are published in English, Spanish, and Vietnamese and are available in alternative format upon request.

CLI is available to assist with all enrollee communication needs related to Medicaid eligibility, the entry process & getting someone approved for services. Service delivery communication is the responsibility of the service provider.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Day Habilitation		
Statutory Service	Prevocational Services		
Statutory Service	Respite Services - Out of Home		
Statutory Service	Shared Living Services		
Statutory Service	Support Coordination		
Statutory Service	Supported Employment		
Extended State Plan Service	Assistive Technology/Specialized Medical Equipment and Supplies		
Extended State Plan Service	Dental		
Other Service	Community Living Supports		
Other Service	Companion Care		
Other Service	Environmental Accessibility Adaptations		
Other Service	Host Home		
Other Service	Housing Stabilization Service		
Other Service	Housing Stabilization Transition Service		
Other Service	Nursing		
Other Service	One-Time Transitional Services		
Other Service	Personal Emergency Response System		
Other Service	Professional Services		
Other Service	Transportation - Community Access		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Day Habilitation Services are aimed at developing activities and/or skills acquisition to support or further community integration opportunities outside of participant's home that promote independence, autonomy and assist him/her in developing a full life in his/her community. Services should focus on habilitation activities that enable the participant to attain maximum skills based on his/her valued outcomes. These services should be provided in a variety of community venues and these venues should routinely correspond with the context of the skill acquisition activity to enhance the habilitation activities. Overarching goals of the program shall include regular community inclusion and the opportunity to build towards maximum independent status for the participant.

The primary focus of Day Habilitation Services is the acquisition of new skills or maintenance of existing skills based on personalized preferences and goals. The skill acquisition/maintenance activities should include formal strategies for teaching the personalized skills and include the intended outcome for the participant. Personalized progress for the skill acquisition/maintenance activities should be routinely reviewed and evaluated with revisions made as necessary to promote continued skill acquisition. As a participant develops new skills, his/her training should move along a continuum of habilitation services offered toward greater independence and self-reliance.

Day Habilitation Services shall focus on enabling the participant to attain his/her maximum skills and shall be coordinated with any physical, occupational, or speech therapies listed in the participant's Plan of Care. In addition Day Habilitation Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Services shall be furnished on a regularly scheduled basis, for one or more days per week based on a 2.5 hour unit of service. The 2.5 hour unit of service must be spent at the service site by the participant. Two units may be billed if the participant spends a minimum of 5 hours at the service site. Any time less than 2.5 hours of service is not billable or payable. No rounding up of hours, such as 4.5 equals 5 is allowed.

Transportation is provided as a component part of day habilitation services and the cost of this transportation is included in the rate paid to providers of day habilitation services.

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

- The Day Habilitation provider is responsible for all transportation between day habilitation sites.
- Transportation is only provided on the day a day habilitation service is provided.
- Time spent in transportation between the participant's residence/location and the day habilitation site is not to be included in the total number of day habilitation services hours per day, except when the transportation is for the purpose of travel training. Travel training must be included in the participant's Plan of Care.
- Cannot be billed for at the same time on the same day as Community Living Supports, Respite-Out of Home, Prevocational Services, or Supported Employment.
- Cannot be billed for at the same time on the same day as Professional services except when there are direct contacts needed in the development of a support plan.

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

- **Participant-directed as specified in Appendix E**
- **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency ☐
Provider Type:
Adult Day Care Center
Provider Qualifications
License *(specify):*
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Adult Day Care.
LAC 48:1.Chapter 50
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necesary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service ☐
Service:
Prevocational Services ☐
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

☐ ☐

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Prevocational Services are prevocational activities designed to assist a participant in acquiring and maintaining basic work-related skills necessary to acquire and retain competitive employment. Overall goals of the program include regular community inclusion and development of work skills and habits to improve the employability of the participant.
Services should be offered which engage workers in real and simulated employment tasks to determine vocational potential. Services focus on teaching concepts and skills such as following directions, attending to task, task completion, problem solving, and job safety skills. All Prevocational Services are to be reflective of the participant's Plan of Care and directed toward habilitation rather than teaching a specific job skill.
The primary focus of Prevocational Services is the acquisition of employment related skills based on the participant's vocational preferences and goals. These activities should include formal strategies for teaching the skills and the intended outcome for the participant. Personalized progress for the activities should be routinely reviewed and evaluated with revisions made as necessary.
Prevocational Services are provided to participants who are working or will be able to work in a paid work setting. Participants need intensive ongoing support to perform in a paid work setting because of their disabilities. In the event participants are compensated in the prevocational services, pay must be in accordance with the United States Fair Labor Standards Act of 1985. If participants are paid in excess of 50% of minimum wage the provider must conduct at a minimum: 6 month formal reviews to determine the suitability of this service rather than Supported Employment services; recommendations to transition the participant to a more appropriate vocational opportunity; and provide the support coordinator with documentation of both the productivity time studies and documented reviews of current placement feasibility.
Prevocational Services are not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71).
Services shall be furnished on a regularly scheduled basis, for one or more days per week based on a 2.5 hour unit of service. The 2.5 hour unit of service must be spent at the service site by the participant. Two units may be billed if the participant spends a minimum of 5 hours at the service site. Any time less than 2.5 hours of service is not billable or payable. No rounding up of hours, such as 4.5 equals 5, is allowed.

Transportation may be provided between the participat's residentce (or other location as agreed upon by the participant or authoirzed representative) and the prevocational dite. Transportation is provided as a componenet part of prevocational servcies and the cost of this transportation is included in the rate paid to providers of prevocational services.

Individual goals are identified and included in the participant's Plan of Care.
These goals are re-assessed at least quarterly, more often as needed and revised as necessary.

As an Employment 1st state, the State's strategy to facilitate participant transition from prevocational services to supported employment and/or employment in the participant's occupation of choice includes individually identifying persons receiving prevocational services and targets them for transition to integrated employment opportunities. This is accomplished through a revised person–centered process prominently featuring the values and principles of the state's Employment1st Initiative. As part of this implementation, the support team must clearly identify integrated community-based vocational goals, action steps and timelines. This is reviewed on at least a quarterly basis and revised as needed. Success is measured by the individual's transition to an integrated employment setting in addition to the state meeting National Core Indicator integrated employment targets.

Individual goals are identified and included in the participant's Plan of Care. Support Coordinators are to monitor and ensure that meaningful activities are occurring and that the participant is not being exploited. Support Coordinators are to re-assess goals at least quarterly, more often as needed and revise as appropriate. Support coordinators are required to visit the participant at the prevocational site to ensure the participant is participating in meaningful activities, are satisfied with services, and free from abuse/neglect. This is documented in the Case Management Information System.

During the person-centered planning process, support coordinators identify various types of activities the participant enjoys participating in or would like to participant in given personal preferences and goals. These activities are included in the participants Plan of Care and monitored to ensure that the participant has the opportunity to participate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
•Services shall be limited to no ore than 8 hours a day, 5 days a week.

The Prevocational provider is responsible for all transportation between Prevocational sites.
- Transportation is only provided on the day a Prevocational service is provided.
- Time spent in transportation between the participant's residence/location and the Prevocational site is not to be included in the total number of Prevocational services hours per day, except when the transportation is for the purpose of travel training. Travel training must be included in the participant's Plan of Care.
- Cannot be billed for at the same time on the same day as Community Living Supports, Respite-Out of Home, Day Habilitation

Services, or Supported Employment.

- Cannot be billed for at the same time on the same day as Professional services except when there are direct contacts needed in the development of a support plan.
- If a participant is compensated, compensation must be less than 50% of minimum wage and must be in accordance with the United States Department of Labor's Fair Labor Standards Act. If a participant is paid above 50% of minimum wage, there must be a review every six months to determine the suitability of continuing Prevocational services or changing vocational services to Supported Employment.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
Adult Day Care
Provider Qualifications

License *(specify):*
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Adult Day Care.
LAC 48:1.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually, and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service
Service:
Respite
Alternate Service Title (if any):

Respite Services - Out of Home

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Respite Services-Out of Home is provided on a short-term basis to participants who are unable to care for themselves due to the absence of or need for relief of caregivers who normally provide care and support. Services are provided by a Center-Based Respite provider.

Federal Financial Participation will be claimed for the cost of room and board only if it is provided as part of respite care furnished in a respite center approved by the State that is not a private residence.

Community activities and transportation to and from these activities in which the participant typically engages in are to be available while receiving Respite Services-Out of Home. These activities should be included in the participant's approved Plan of Care. This will provide the participant the opportunity to continue to participate in typical routine activities. Transportation costs to and from these activities is included in the Respite Services-Out of Home rate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite Services-Out of Home are limited to 720 hours per Plan of Care year. The process for approving hours in excess of 720 hours must go through the established approval process with proper justification and documentation.

Cannot be provided in a personal residence

Respite Services-Out of Home is not a billable waiver service to participants receiving the following services:
- Companion Care
- Host Home
- Shared Living

Payment will not be made for:
- Transportation-Community Access

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

- **Participant-directed as specified in Appendix E**
- **Provider managed**

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

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Center-Based Respite Care

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Services - Out of Home

Provider Category:

Agency

Provider Type:

Center-Based Respite Care

Provider Qualifications

License *(specify):*

Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Center-Based Respite.

LAC 48:1.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:

Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Shared Living Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Shared Living services are provided to a participant in his/her home and community to achieve, improve, and/or maintain social and adaptive skills necessary to enable the participant to reside in the community and to participate as independently as possible. Shared Living services focus on the participant's preferences and goals. Supports provided are related to the acquisition, improvement, and maintenance in level of independence, autonomy, and adaptive skills and are to be included in each participant's Plan of Care. This includes self-care skills, adaptive skills, and leisure skills with the overall goal of providing the participant the ability to successfully reside with others in the community while sharing supports. Shared Living services take into account the compatibility of the participants sharing services which includes individual interests, age of the participants, and the privacy needs of

each participant. Each participant's essential personal rights of privacy, dignity and respect, and freedom from coercion are protected.

The Shared Living setting is selected by each participant among all available alternatives and identified in each participant's Plan of Care. Each participant has the ability to determine whether or with whom they share a room. Each participant has the freedom of choice regarding daily living experiences which includes meals, visitors, and activities. Each participant is not limited in opportunities to pursue community activities.

Shared Living services must be agreed to by each participant and the health and welfare must be able to be assured for each participant. If the person has a legal guardian, their approval must also be obtained. Each participant's Plan of Care must reflect the Shared Living services and include the shared rate for the service indicated.

The Shared Living service setting is integrated in, and facilitates each participant's full access to the greater community, which includes opportunities for each participant to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities.
Shared Living service providers are responsible for providing 24-hour staff availability along with other identified responsibilities as indicated in each participant's individualized Plan of Care. This includes each participant's routine daily schedule and ensuring the health and welfare of each participant while in their place of residence, community and for any other waiver services provided by the Shared Living services provider.
Shared Living services may be provided in a residence that is owned or leased by the provider or that is owned or leased by the participant. Services may not be provided in a residence that is owned or leased by any legally responsible relative of the participant. If Shared Living services are provided in a residence that is owned or leased by the provider, any modification of the conditions must be supported by specific assessed needs and documented in the participant's Plan of Care. The provider is responsible for the cost of and implementation of the modification when the residence is owned or leased by the provider.
In a provider-owned or controlled residential setting, the following additional conditions must be met. Any modifications of the conditions must be supported by a specific assessed need and documented in the Plan of Care:

- The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the participant receiving services, and the participant has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, parish, city, or other designated entity.
- Each participant has privacy in their sleeping or living unit which includes:
  - o Units have lockable entrance doors, with appropriate staff having keys to doors;
  - o Participants share units only at the participant's choice; and
  - o Participants have the freedom to furnish and decorate their sleeping or living units;
- Participants have the freedom and support to control their own schedules and activities, and have access to food at any time;
- Participants are able to have visitors of their choosing at any time; and
- The setting is physically accessible to the participant.

The Shared Living services rate includes the cost of transportation. The provider is responsible for providing transportation for all community activities except for vocational services. Transportation for vocational services is included in the rate of the vocational service.

All Shared Living service participants are required to have an individualized back-up staffing plan and an individualized emergency evacuation plan which are to be submitted with their Plan of Care.
Shared Living services may be shared by up to six participants and who have a common Shared Living provider agency.
Shared Living services are not located in a building that is a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex. Shared Living services are not provided in settings that are isolated from the larger community.
Family members who provide Shared Living services must meet the same standards as unrelated provider agency staff.

ICF/DD providers who convert an ICF/DD to an SIL via the shared living conversion model must be approved by OCDD and licensed by HSS prior to providing services in this setting, and prior to accepting any ROW participant or applicant for residential or any other developmental disability service(s).

An ICF/DD provider who elects to convert to an SIL via the shared living conversion process shall obtain the approval of all of the residents of the home(s) (or the responsible parties for these residents) regarding the conversion of the ICF/DD prior to beginning the process of conversion.

ICF/DD providers who elects to convert to an SIL via the shared living conversion process shall submit a licensing application for a HCBS provider license, SIL Module.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Shared Living services aren't available to participants 17 and under.

All Medicaid State Plan nursing services must be utilized and exhausted.
Payment will not be made for services provided by a relative who is a:

- Parent(s) of a minor child;
- Legal guardian of an adult or child with developmental disabilities;

- Parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or
- Spouse

The Shared Living staff may not live in the participant's place of residence.
Payment does not include room and board or maintenance, upkeep and improvement of the participant's or provider's property.
Payment will not be made for the following services:
- Community Living Supports
- Companion Care
- Host Home
- Respite Care Services-Out of Home
- Transportation-Community Access
- Environmental Accessibility Adaptations (if housing is leased or owned by the provider)

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Shared Living

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Shared Living Services

Provider Category:
Agency
Provider Type:
Shared Living
Provider Qualifications
License *(specify):*
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Supervised Indedepent Living and/or Supervised Independent Living-Conversion.
LAC 48:1.Chapter 50
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Support Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Support Coordination services are provided to all participants to provide assistance in gaining access to needed waiver services, Medicaid State Plan services, as well as needed medical, social, education, and other services, regardless of the funding source for the services. Support Coordination services includes assistance with the selection of service providers, development/revision of the Plan of Care, and monitoring of services.

When participants choose to Self-Direct services, Support Coordination services provide information, assistance, and management of the service being Self-Directed. This includes assisting the participant in reviewing, understanding, and completing the activities as identified in the Self-Direction Employer Handbook. The handbook includes information and procedures related to the participant's employer activities necessary for self-employment of services. Specific activities the Support Coordination services assists with include recruitment techniques, interviewing strategies, verification of employee qualifications, hiring of staff, staff scheduling, time sheet documentation, staff duties, employee performance evaluation, and termination of staff. Support Coordination services includes on-going support and assistance to the participant.

ROW will utilize support coordination for assisting with the moving of individuals from the institutions; up to ninety consecutive days or per DHH policy, but not to exceed 180 days will be allowed for transition purposes. Payment will be made upon certification and may be retroactive no more than ninety days or per DHH policy, but not to exceed 180 days prior to certification date.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
OCDD Supports and Services Centers are prohibited from providing Case Management/Support Coordination services in the Residential Options Waiver (ROW).

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

- **Participant-directed as specified in Appendix E**
- **Provider managed**

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

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:
Agency
Provider Type:
Case Management
Provider Qualifications
License *(specify):*
Case Management
LAC 48:1 Chapter 49 (8/20/94)
Certificate *(specify):*

Other Standard *(specify):*
Louisiana identifies "Case Management" as "Support Coordination." Support Coordinators' qualifications are the same as case managers.

Case Manager and Case Manager Supervisor Qualifications: Must meet the following:

- Bachelor or Master Degree in social work from a program accredited by the Council on Social Work Education; or
- Bachelors or Master Degree in nursing (RN)currently licensed in Louisiana (one year of paid experience will substitute for the degree); or
- Bachelor or Master Degree in a human service field which includes; psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation; or
- Bachelor in liberal arts or general studies with a concentration of at least 16 hours in a human service field which includes; psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation

Case Management Supervisor qualifications include an additional two years of paid post degree experience in providing case management services.

All training as identified and mandated by DHH is required in addition to the following:

Orientation and Training for New Employees

New Staff Orientation
- Orientation of at least sixteen (16) hours must be provided to all staff, volunteers, and students within five (5) working days of employment
- A minimum of eight (8) hours of the orientation training must cover orientation to the target population including, but not limited to, specific service needs and resources

This orientation must include, at a minimum the following:
- Case Management Provider policies and procedures
- Medicaid and other applicable DHH policies and procedures
- Confidentiality
- Documentation in case records
- Participant rights protection and reporting of violations
- Participant abuse and neglect reporting policies and procedures
- Recognizing and defining abuse and neglect
- Emergency and safety procedures
- Data management and record keeping
- Infection control and universal precautions
- Working with the target or waiver populations
- Professional ethics
- Outcome measures

Training for New Staff
- In addition to the required sixteen (16) hours of orientation, all new employees with no documented training must receive an additional minimum sixteen (16) hours of training during the first ninety (90) calendar days of employment
- Training must be related to the target or waiver populations to be served and include specific knowledge, skills, and techniques necessary to provide case management to the target or waiver populations
- Training must be provided by an individual with demonstrated knowledge of both the training topics and the target or waiver populations

This training must include at a minimum the following:
- Assessment techniques
- Support and service planning
- Support and service planning for people with complex medical needs, including information on bowel management

aspiration, decubitus, nutrition
- Resource identification
- Interviewing and interpersonal skills
- Data management and record keeping
- Cultural awareness
- Personal outcome measures

A new employee may not be given case management responsibility until the orientation is satisfactorily completed. NOTE: Routine supervision may not be considered training.

Annual Training
- It is important for case managers to receive continuing training to maintain and improve skills. Each case manager must satisfactorily complete forty (40) hours of case-management related training annually which may include training updates on subjects covered in orientation and initial training. Case managers' annual training year begins with the date of hire.

- The sixteen (16) hours of training for new staff required in the first ninety (90) days of employment may be part of the forty (40) hour minimum annual training requirement. Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required forty (40) hours of annual training.

The following is a list of suggested additional topics for training:
- Nature of illness or disability, including symptoms and behavior
- Pharmacology
- Potential array of services for the population
- Building natural support systems
- Family dynamics
- Developmental life stages
- Crisis management
- First aid/CP
- Signs and symptoms of mental illness, alcohol and drug addiction, mental retardation/developmental disabilities and head injuries
- Recognition of illegal substances
- Monitoring techniques
- Advocacy
- Behavior management techniques.
- Values clarification/goals and objectives
- Available community resources
- Accessing special education services
- Cultural diversity
- Pregnancy and prenatal care
- Health management
- Team building/interagency collaboration
- Transition/closure
- Age and condition-appropriate preventive health care
- Facilitating team meetings
- Computers
- Stress and time management
- Legal issues
- Outcome measures
- Person-centered planning
- Self-determination or recipient-directed services

Training for Supervisors
Each case management supervisor must complete a minimum of forty (40) hours of training a year. In addition to the required and suggested topics for case managers, the following are suggested topics for supervisory training:
- Professional identification/ethics
- Process for interviewing, screening, and hiring of staff
- Orientation/in service training of staff
- Evaluating staff
- Approaches to supervision
- Managing caseload size
- Conflict resolution
- Documentation
- Time management

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ☐

Service:

Supported Employment ☐

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
☐	☐
Category 2:	**Sub-Category 2:**
☐	☐
Category 3:	**Sub-Category 3:**
☐	☐
Category 4:	**Sub-Category 4:**
☐	☐

Service Definition *(Scope):*

Supported Employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the participant is working toward competitive work, consistent with strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice with ongoing support services for whom competitive employment has not traditionally occurred. Supported Employment services are provided to participants who are not served by Louisiana Rehabilitation Services or through a local education agency under IDEA and who need more intense, long term follow along and usually cannot be competitively employed because supports cannot be successfully faded. Some examples of Supported Employment are:

1. Individual placement: A supported employment placement strategy in which an employment specialist (job coach) assists a person locating competitive employment, providing training and supporting, then gradually reducing time and assistance at the worksite.
2. Services that assist a participant to develop and operate a micro-enterprise. This assistance consists of: (a) assisting the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance related to developing and launching a business; (c) identification of the supports that are necessary for the participant to operate the business; and, (d) ongoing assistance, counseling and guidance once the business has been launched.
3. Enclave: An employment situation in competitive employment in which a group of eight or fewer workers with disabilities are working at a particular work setting performing similar general job tasks. The disabled workers may be disbursed throughout the company and among non-disabled workers or congregated as a group in one part of the business.
4. Mobile Work Crew: A group of eight or fewer workers with disabilities who perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor).

The required minimum number of service hours per day per participant are as follows:
1) Individual placement - 1 hour;
2)Services that assist a participant to develop and operate a micro-enterprise - 1 hour;
3)Enclave -2.5 hours; and 4) Mobile Work Crew - 2.5 hours.
Any time less than the mimimum number of hours of service specified above for any model is not billable or payable.

The units of service for models numbered 1 and 2 above are one hour spent on the job site or training with the job coach per

participant per day.

The units of service for models 3 and 4 above are a minimum of 2.5 hours spent at the job site per participant per day. Two half-day units may be billed if the participant spends a minimum of 5 hours spent at the service site. No rounding up of hours, such as 4.5 equals 5 hours is allowed.
FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Supported Employment Services may be delivered either by an Adult Day Center or a Community Rehabilitation Program provider.

The state intends to strategically move from segregated employment toward individual employment with a significant increase individual employment being a long-term goal. The general strategy for transitioning current waiver participants into integrated employment activities includes training and education (participants, family, support coordinators, providers, etc.). The participant's planning process will be person-centered and focus on employment activities the participant wishes to pursue. This will take into account, personal interests and abilities and identify any supports that the participant may need to be successfully employed
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Cannot be billed for the same time as any of the following services:
Community Living Supports
Professional Services (except those direct contacts needed to develop a behavioral management plan) Respite Services - Out of Home.

When Supported Employment services are provided at a work site in which persons without disabilities are employees, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, but payment will not be made for the supervisory activities rendered as a normal part of the business setting.

Not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401(16) and (71).

Provider is responsible for all transportation from the agency to all work sites related to the provision of services. Transportation to and from the service site is offered and billable as a component of the Supported Employment Service.

Transportation is payable only when a supported employment service is provided on the same day.

Time spent in transportation to and from the program shall not be included in the total number of services hours provided per day.

Participant may receive more than one type of vocational /habilitation service per day as long as the billing criteria is followed and as long as the requirements for the minimum time spent on site are adhered to.

Billing for multiple vocational/habilitative services at the same time is prohibited.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Center
Agency	Community Rehabilitation Program

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency ☐

Provider Type:
Adult Day Center
Provider Qualifications
License *(specify):*
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the Module requirements for Adult Day Care.
LAC 48:1.Chapter 50
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually, and as necessary.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Community Rehabilitation Program
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Louisiana Rehabilitation Services Compliance Certificate
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Rehabilitation Services
Frequency of Verification:
Initially, annually, and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Assistive Technology/Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Assistive Technology/Specialized Medical Equipment and Supplies service includes providing specialized devices, controls, or appliances which enable a participant to increase his/her ability to perform activities of daily living, ensure safety, and/or to perceive, control, and communicate within his/her environment. This service also includes medically necessary durable and non-durable equipment not available under the Medicaid State Plan and repairs to such items and equipment necessary to increase/maintain the independence and well being of the participant. All equipment, accessories and supplies must meet all applicable manufacture, design and installation requirements.

This service includes:
- Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
- Necessary medical supplies not available under the State Plan.
- Repair of all items purchased,
- The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
- Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for participants;
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordination of necessary therapies, interventions, or services with assistive technology devices;
- Training or technical assistance on the use for the participant, or, where appropriate, family members, guardians, advocates, authorized representatives of the participant, professionals, or others.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Must first access and exhaust items furnished under State Plan

Excludes items that are not of direct medical or remedial benefit to the participant

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

- **Participant-directed as specified in Appendix E**
- **Provider managed**

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

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Devices

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Assistive Technology/Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Assistive Devices
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as a Medicaid HCBS provider.

Documentation on manufacturer's letterhead that the agency listed on the Louisiana Medicaid Enrollment Form and Addendum (PE-50) is:

- Authorized to sell and install
  - o Assistive Technology,
  - o Specialized Medical Equipment and Supplies, or
  - o Devices for assistance with activities of daily living

and

- Has training and experience with the application, use fitting and repair of the equipment or devices they propose to sell or repair

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Fiscal Intermediary (Current Contractor is Molina)

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Dental

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Dental services include adult diagnostic, preventative, restorative, endodontic, periodontic, removable prosthodontic, maxilla facial prosthetic, fixed prosthodontic, oral and maxilla facial surgery, orthodontics, adjunctive general services, and dentures.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ROW Dental services are not available to children (up to 21 years of age). Children access dental services through EPSDT.

All available Medicaid State Plan services must first be exhausted prior to accessing ROW Dental services.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dentist-Individual or Group

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental

Provider Category:
Agency
Provider Type:
Dentist-Individual or Group
Provider Qualifications
License *(specify):*
Dentistry License
LA RS 37:751, 37:753
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana State Board of Dentistry
Frequency of Verification:
Initially and every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Living Supports

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Community Living Supports are provided to a participant in his/her own home and in the community to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, provide relief of the caregiver, and inclusion in the community.
Community Living Supports focus on the achievement of one or more goals as indicated in the participant's approved Plan of Care by incorporating teaching and support strategies. Supports provided are related to the acquisition, improvement, and maintenance in level of independence, autonomy, and adaptive skills. This includes self-help skills, socialization skills, cognitive skills, and communication skills.

Community Living Supports may be shared by up to three participants who may or may not live together and who have a common direct service provider agency. Shared services must be agreed to by each participant and the health and welfare must be able to be assured for each participant. If the person has a legal guardian, their approval must also be obtained. Each participant's Plan of Care must reflect shared services and include the shared rate for the service indicated.

The cost of transportation is built in to the Community Living Services rate and must be provided when integral to Community Living Services.

All Community Living Services participants are required to have an individualized back-up staffing plan and an individualized emergency evacuation plan which are to be submitted with their Plan of Care.

Family members who provide Community Living Supports must meet the same standards as unrelated provider agency staff.

Community Living Supports may be a self-directed service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payment will not be made for services provided by a relative who is:
- Parent(s) of a minor child;
- Legal guardian of an adult or child with developmental disabilities;
- Parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or
- Spouse

Payment will not be made for routine care and support that is normally provided by the participant's family or for services furnished to a minor by the child's parent or step-parent or by a participant's spouse.

Community Living Supports staff are not allowed to sleep during billable hours of Community Living Supports.

The participant and Community Living Supports staff may not live in the same place of residence.

Payment does not include room and board or maintenance, upkeep and improvement of the provider's or family's residence.

Community Living Supports may not be provided in a licensed respite care center.

Payment will not be made for:
- Transportation to and from Supported Employment, Day Habilitation, or Prevocational Services, as transportation for these services are included in each vocational service.

May not be billed at the same time on the same day as:
- Transportation-Community Access
- Day Habilitation
- Prevocational Services
- Supported Employment
- Respite Care Services-Out of Home

Community Living Supports are not available to participants receiving any of the following services:
- Companion Care
- Host Home
- Shared Living

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

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

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Direct Support Worker
Agency	Personal Care Attendant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:
Individual

Provider Type:
Direct Support Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The following individual qualifications are required for the direct care staff person for the Self-Direction Program:

- Be at least 18 years of age;
- Have a high school diploma, GED, or trade school diploma in the area of human services, or demonstrated competency, or verifiable work experience in providing support to persons with disabilities;
- Must pass a criminal history background check;
- Possess a valid social security number;
- Provide documentation of current Cardiopulmonary Resuscitation and First Aid Certifications.

Additionally, direct service workers must be able to complete the tasks indicated on the participant's Plan of Care. This training may be provided by the family or through a training facility. Documentation, signed by the participant/authorized representative and support coordinator, which indicates the worker is able to complete the tasks indicated on the participant's Plan of Care must be submitted to the fiscal agent before the employee can be hired. All training documentation must be kept in the participant's home book for monitoring and review by the support coordinator during quarterly home visits.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal/employer agent (Current contractor is Acumen)

Frequency of Verification:
Initially, annually and as needed.

The fiscal agent is responsible to verify that direct support workers have met qualifications. The fiscal agent at the respective 1 and 3 year intervals based on the type of training needing re-certification, will notify each direct support worker and the OCDD Self-Direction Program Manager. The fiscal agent will update their file with documentation of training as each required re-certification is completed. The fiscal agent will continue to notify the OCDD Self-Direction Program Manager for monitoring purposes until all required re-certifications have been completed.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:
Agency
Provider Type:
Personal Care Attendant
Provider Qualifications
License *(specify):*
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Personal Care Attendant.
LAC 48:1.Chapter 50
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually, and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Companion Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Companion Care services provide personal care and supportive services to a participant who resides as a roommate with his/her caregiver. Companion Care services provide supports to assist the participant in achieving and/or maintaining increased independence, productivity, and community inclusion as identified in the participant's Plan of Care.

Companion Care providers assist the participant in locating an appropriate companion who will be compatible with the participant. The companion is an employee of the provider agency and is paid as such by the provider. The provider assists in the development of an agreement between the participant and companion. The agreement defines all shared responsibilities between the participant and companion including a typical weekly schedule. This agreement becomes a part of the participant's Plan of Care. Revisions to this agreement must be facilitated by the provider and approved as part of the participant's Plan of Care following

the same process as would any revision to a Plan of Care. Revisions can be initialized by the participant, the companion, the provider, or a member of the participant's support team.

The provider will conduct an initial inspection of the participant's home with on-going periodic inspections with a frequency determined by the provider. The provider will contact the Companion at a minimum, once per week, or more often as specified in the participant's Plan of Care.

Responsibilities of the Companion include:
- Providing assistance with Activities of Daily Living (ADLs)
- Community integration
- Providing transportation
- Coordinating and assisting as needed with transportation to medical/therapy appointments
- Participating in and following the participant's Plan of Care and any support plans
- Maintaining documentation /records in accordance with State and provider requirements
- Being available in accordance with a pre-arranged time schedule as outlined in the participant's Plan of Care
- Purchasing own personal items and food.
- Being available 24 hours a day (by phone contact) to the participant to provide supports on short notice as a need arises

The provider is responsible for providing 24 hour oversight, back-up staff, and companion supervision. The provider must provide relief staff for scheduled and unscheduled absences, available for up to 360 hours (15 days) per Plan of Care year. The Companion Care provider's rate includes funding for relief staff for scheduled and unscheduled absences.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Companion Care services are not available to participants under the age of 18.

Payment will not be made for services provided by a relative who is a:
- Parent(s) of a minor child;
- Legal guardian of an adult or child with developmental disabilities;
- Parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or
- Spouse

Payment will not be made for:
- Community Living Supports
- Shared Living
- Host Home
- Respite Care Services-Out of Home
- Transportation-Community Access

Payment does not include room and board or maintenance, upkeep and improvement of the participant's or provider's property.

Transportation to and from vocational programs are to be billed by the vocational provider as this is included in the specific vocational service rate.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Attendant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Care

Provider Category:
Agency ☐
Provider Type:
Personal Care Attendant

Provider Qualifications

License *(specify):*
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Personal Care Attendants.
LAC 48:1.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Environmental Accessibility Adaptations include physical adaptations to the participant's home or vehicle which are necessary to ensure health, welfare and safety to the participant, or which enable the participant to function with greater independence, without which the participant would require additional supports or institutionalization. Environmental Adaptations must be specified in the participant's Plan of Care.

Home Adaptations:

Home adaptations pertain to modifications that are made to a participant's primary residence. Such adaptations to the home may include bathroom modifications, ramps, other adaptations to make the home accessible to the participant. The service must be for a specific approved adaptation.

- May be used only to cover the difference between constructing the adaptive component and building an accessible or modified component. The service must for a specific approved adaptation;

• May be applied to rental or leased property only with the written approval of the landlord and approval of OCDD Regional Waiver Supports and Services Offices and/or Human Services Authorities or Districts;
• May include the performance of necessary assessments to determine the type(s) of modification(s) that are necessary;
• May include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant;

Vehicle Adaptations:

Vehicle adaptations pertain to modifications that are made to a vehicle which is the participant's primary means of transportation. Such adaptations to the vehicle may include a lift, or other adaptations to make the vehicle accessible to the participant or for the participant to drive. Vehicle adaptations may include the performance of necessary assessments to determine the type(s) of necessary modifications. The service must be for a specific approved adaptation.

Adaptations to home and vehicle include the following:
• Training the participant and provider in the use and maintenance of the Environmental Adaptation(s);
• Repair of equipment and or devices, including battery purchases for vehicle lifts and other reoccurring replacement items that contribute to the ongoing maintenance of the approved adaptation(s) and
• Standard manufacturer provided service contracts and warranties.
• Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District.

All Environmental Accessibility Adaptations to home and vehicle must meet all applicable standards of manufacture, design and installation.

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

Home adaptation exclusions:
• Not intended to cover basis construction cost. May not include modifications which add to the total square footage of the home except when the additional square footage is necessary to make the required adaptations function appropriately. (For example, if a bathroom is very small and a modification cannot be done without increasing the total square footage, this would be considered as an approvable cost). When new construction or remodeling is a component of the service, payment for the service is to only cover the difference between the cost of typical construction and the cost of specialized construction.
• May not include modifications to the home which are of general utility and not of direct medical or remedial benefit to the participant (i.e., flooring, roof repair, central air conditioning, hot tubs, swimming pools, exterior fencing, general home repair, maintenance, etc).
• May not be furnished to adapt living arrangements that are owned or leased by paid caregivers or providers of waiver services; and
• Service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g. extended warranties, extended service contracts)

Vehicle adaptation exclusions:
• Modifications which are of general utility and are not of direct medical or remedial benefit to the participant;
• Purchase or lease of a vehicle;
• Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications;
• Car seats; and
• Service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g. extended warranties, extended service contracts)

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

- **Participant-directed as specified in Appendix E**
- **Provider managed**

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

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Modification Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Environmental Modification Agency
Provider Qualifications
License *(specify):*
Home Adaptations:
Current license from the State Licensing Board of Contractors for any of the following building trade classifications:
- General Contractor
- Home Improvement
- Residential Building

Or
If a current Louisiana Medicaid provider of Durable Medical Equipment, documentation from the manufacturing company (on their letterhead) that confirms the provider is an authorized distributor of a specific product that attaches to a building. Letter must specify the product and state that the provider has been trained on its installation.

Vehicle Adaptations:
Current license by the Louisiana Motor Vehicle Commission as a "Specialty Vehicle Dealer" and accreditation by the National Mobility Equipment Dealers Association under the "Structural Vehicle Modifier"

All Environmental Adaptations providers must comply with all applicable Local (City or Parish) Occupational License (s).
Certificate *(specify):*

Other Standard *(specify):*
All Environmental Adaptation providers must meet any state or local requirements for licensure or certification, as well as the person performing the service (i.e., building contractors, plumbers, electricians, engineers, etc.). When state and local building or housing code standards are applicable, modifications to the home shall meet such standards and all services shall be provided in accordance with applicable State or local requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
State Medicaid Agency though Medical Fiscal Intermediary
Frequency of Verification:
Initially and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Host Home

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Host Home services are personal care and supportive services provided to a participant who lives in a private home with a family who is not the participant's parent, legal representative, or spouse. Host Home Families are a stand-alone family living arrangement in which the principle caregiver int he Host Home assumes the direct responsibility for the participant's physical, social, and emotional well-being and growth in a family environment. Host Home services are to take into account compatibility with the Host Home Family members including age, support needs, privacy needs.

If the participant is a child, the Host Home Family is to provide the supports required to meet the needs of a child as any family would for a minor child. Support needs are based on the child's age, capabilities, health, and special needs. A Host Home Family can provide compensated supports for up to two participants, regardless of the funding source.

Host Home services include assistance with personal care, leisure activities, social development, family inclusion, and community inclusion. Natural supports are also encouraged and supported when possible. Supports are to be consistent with the participant's skill level, goals, and interests.

Host Home Provider:
- Ensure availability, quality and continuity of Host Home services
- Arrange, train, and oversee Host Home services (Host Home Family)
- Have 24 hour responsibility which includes back-up staffing for scheduled and unscheduled absences of the Host Home Family for up to 360 hours (15 days) as authorized by the participant's Plan of Care)
- Relief staffing may be provided in the participant's home or in another Host Home Family's home.

Host Home Family:
- Must attend participant's Plan of Care meeting and participate including providing information needed in the development of the plan
- Must follow all aspects of the participant's Plan of Care and any support plans
- Must assist the participant in attending appointments (i.e., medical, therapy, etc.)
- Must provide transportation as would a natural family member
- Must maintain participant's documentation
- Must follow all requirements for staff as in any other waiver service

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payment will not be made for services provided by a relative who is a:
- Parent(s) of a minor child;
- Legal guardian of an adult or child with developmental disabilities;
- Parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or
- Spouse

Children eligible for Title IV-E services are not eligible for Host Home services.

Payment does not include room and board or maintenance, upkeep and improvement of the Host Home Family's residence. Environmental Adaptations are not available to participant's receiving Host Home services since the participant's place of residence is owned or leased by the Host Home Family.

Payment will not be made for:
- Community Living Supports
- Companion Care
- Shared Living
- Respite Care Services-Out of Home
- Transportation-Community Access
- One-Time Transition Services

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Substitute Family Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Host Home

Provider Category:
Agency
Provider Type:
Substitute Family Agency
Provider Qualifications

License *(specify):*
Children:
Class A Child Placing Agency License
Act 286 of 1985, LAC Title 48 Chapter 41

Adults:
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Substitute Family Care.
LAC 48:1.Chapter 50
Certificate *(specify):*

Other Standard *(specify):*
Host Home Service provider agencies must meet the following qualifications:

- Have experience in delivering therapeutic services to persons with developmental disabilities;
- Have staff who have experience working with persons with developmental disabilities; and
- Screen, train, oversee and provide technical assistance to the Host Home Family in accordance with OCDD requirements including the coordination of an array of medical, behavioral and other professional services geared to persons with DD; and
- Must provide on-going assistance to the Host Home Family so that all HCBS waiver health and safety assurances, monitoring and critical incident reporting requirements are met.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Family and Child Services (Bureau of Licensing)

Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Housing Stabilization Service

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Housing Stabilization Service enables waiver participants to maintain their own housing as set forth in the participant's approved plan of care (POC). Services must be provided in the home or a community setting. The service includes the following components:

1. Conduct a housing assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, accommodations needed, other important preferences) and needs for support to maintain housing (including access to, meeting terms of lease, and eviction prevention), budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
2. Assist participant to view and secure housing as needed. This may include arranging or providing transportation. Assist participant to secure supporting documents/records, completing/submitting applications, securing deposits, locate furnishings.
3. Develop an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal.
4. Participate in the development of the plan of care, incorporating elements of the housing stabilization service provider plan. Participate in plan of care renewal and updates as needed.
5. Provide supports and interventions per the individualized housing stabilization service provider plan. If additional supports or services are identified as needed outside the scope of Housing Stabilization Services, communicate the needs to the Support Coordinator.
6. Communicate with the landlord or property manager regarding the participant's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager.
7. If at any time the participant's housing is placed at risk (eg.,eviction, loss of roommate or income), Housing Stabilization Services will provide supports to retain housing or locate and secure housing to continue community based supports including locating new housing, sources of income, etc.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Available only to participants who:

- Are residing in a State of Louisiana Permanent Supportive Housing unit or
- Are linked for the State of Louisiana Permanent Supportive Housing selection process

Limited to:

- No more than 165 combined units of this service and the Housing Stabilization Transition service (units can only be exceeded with written approval from OCDD)

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

- **Participant-directed as specified in Appendix E**
- **Provider managed**

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

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Permanent Supportive Housing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Stabilization Service

Provider Category: