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PROVIDER REQUIREMENTS

All home and community-based services (HCBS) delivered through a 1915(c) waiver must be provided in ~~settings~~ accordance with the following qualities:

~~Under the Home and Community Based Services (HCBS) Settings Rule, implemented on 3/17/2014~~ March 17, 2014, the setting, where waiver services are provided, should have the following qualities in order to be considered a compliant setting:

1. ~~Is i~~ Integrated in and supports access to the greater community;
2. ~~Provides~~ opportunities to seek employment and work in competitive and integrated settings, engage in community life and control personal resources;
3. ~~Ensures~~ that the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS services;
4. ~~Allow for a setting Is ss~~ Selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting;
5. ~~Ensures~~ an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint;
6. ~~Optimizes~~ individual initiative, autonomy and independence in making life choices; and
7. ~~Facilitates~~ individual choice regarding services and supports and who may provide said services and supports.

In addition to the above qualities, residential provider-owned/controlled settings must have the following qualities:

1. The specific unit/dwelling must be owned, rented, or occupied under a legally enforceable agreement/lease;
2. Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, parish, city or other designated entity;

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3. If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law;
4. Each individual has privacy in their sleeping or living unit;
5. Units have lockable entrance doors, with the individual and appropriate staff members having keys to doors as needed;
6. Individuals who are sharing units have a choice of roommates;
7. Individuals have the freedom to furnish and decorate their sleeping or living units within the limits imposed by the lease or other agreement;
8. Individuals have the freedom and support to control their schedules and activities and have access to food at any time;
9. Individuals may have visitors at any time; and
10. The setting is physically accessible to the individual.

Provider participation in the Louisiana Medicaid program is voluntary. In order to participate in the Medicaid program, a provider must:

1. Meet all of the requirements for licensure as established by applicable state laws and rules promulgated by the Louisiana Department of Health (LDH);
2. Agree to abide by all applicable rules and regulations established by the Centers for Medicare and Medicaid Services (CMS), LDH, and other state agencies; and
3. Comply with all the terms and conditions for Medicaid enrollment.

Providers must attend all mandated meetings and training sessions as directed by the Office for Citizens with Developmental Disabilities (OCDD) or the Local Governing Entity (LGE) as a condition of enrollment and continued participation as a waiver provider. A provider Enrollment Packet must be completed for each LDH administrative region in which the agency will provide services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have completed the Home and Community-Based Services (HCBS) training related to compliance with the HCBS Settings Rule Louisiana Administrative Code (LAC) Title XXI Chapter 9. Provider Requirements for participation in the waiver programs mandate that the provider has been issued a Medicaid provider number.

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[Providers must participate in the initial trainings for prior authorization and data collection, as well as any training provided on changes in the system. Initial training is provided at no cost to the agency. Any repeat training must be paid for by the requesting agency.](#)

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Providers must have available computer equipment, software, and internet connectivity necessary to participate in trainings, prior authorization (PA), data collection, and ~~Electronic Visit~~ verification (EVV).

It is the provider’s responsibility to ensure that ~~the~~ use of contractors, including the use of independent contractors, complies with all state and federal laws, rules and/or regulations, including those regarding LAC Title XXI Chapter 9. Provider Requirements~~the HCBS Settings Rule~~ and those enforced by the United States Department of Labor.

All residential providers must maintain a toll-free telephone line with 24-hour accessibility manned by either a staff member or an answering service. This toll-free number must be given to beneficiaries at either intake or the first meeting.

Brochures providing information on the agency’s experience must include the agency’s toll-free number along with the OCDD’s toll-free information number. OCDD must approve all brochures prior to use.

Providers must develop a Quality Improvement and Self-Assessment Plan. This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. The first ~~Self-Assessment~~ is due six (6) months after approval of the Quality Improvement Plan (QIP), and annually thereafter.

The ~~Quality Improvement Plan~~QIP must be submitted for approval within sixty (60) days after the training is provided by LDH.

Providers must be certified for a period of one (1) year. Re-certification must be completed no less than sixty (60) days prior to the expiration of the certification period.

The agency must not be excluded from participation in Louisiana Medicaid as an entity as evidenced by an open exclusion on the Louisiana State Adverse Actions database, the Office of Inspector General’s (OIG) national exclusions database, or the federal System for Award Management (SAM) database. The agency also must not have an outstanding Medicaid ~~P~~program audit exception or other unresolved financial liability owed to the state.

Changes in the following areas are to be reported in writing to the ~~Office of the Secretary~~LDH, ~~Bureau of Health Services Financing~~ Health Standards Section (HSS), to OCDD, and to the ~~F~~fiscal Intermediary’s Provider Enrollment Section in at least ten (10) days prior to any change:

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1. Ownership;
- ~~2.~~ Physical location;
3. Mailing address;
4. Telephone number; and/or
5. Account information affecting electronic funds transfer (EFT).

The provider must complete a new provider enrollment packet when a change in ownership of five percent (5%) to fifty percent (50%) of the controlling interest occurs, but the provider may continue serving beneficiaries. When fifty-one percent (51%) or more of the controlling interest is transferred, a complete re-certification process must occur, and the agency shall not continue serving beneficiaries until the re-certification process is complete. Beneficiaries should be offered a new freedom of choice when this occurs.

Waiver services are to be provided only to persons who are waiver beneficiaries and in strict accordance with the provisions of the approved ~~P~~lan of ~~C~~are (POC) and ~~home and community based services (HCBS)~~ ~~HCBS~~-guidance.

Providers may not refuse to serve any waiver beneficiary that chooses their agency unless there is documentation to support an inability to meet the individual’s health, safety, and welfare needs, or all previous efforts to provide services and supports have failed and there remains no option but to refuse services. Such refusal to serve an individual must be made in writing by the provider and include a detailed explanation as to why the provider is unable to serve the individual. Written notification must be submitted to the LGE. Providers who contract with other entities to provide waiver services must maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver beneficiary referred to it by the enrolled direct service provider agency.

The beneficiary’s provider and support coordination agency (SCA) must have a written working agreement that includes the following:

1. Written notification of the time frames for POC planning meetings;
2. Timely notification of meeting dates and times to allow for provider participation, which includes all providers who are providing a service on the POC;

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3. Information on how the agency is notified when there is a POC or service delivery change; and
4. Assurance that the appropriate provider representative is present at planning meetings as invited by the beneficiary.

The Supports Waiver (SW) services outlined below may be provided by the provider or by an agreement with other contracted agents. The actual provider of the service, whether it is the provider or a subcontracted agent, must meet the following licensure or other qualifications:

<u>Waiver Service</u>	<u>Requirements</u>	<u>Service Provided by</u>
<u>Support Coordination</u>	<u>Case Management License</u> Providers of support coordination for the SW program must have a signed performance agreement with OCDD to provide services to waiver beneficiaries. <del>Support coordination agencies</del> SCAs must meet all of the performance agreement requirements in addition to any additional criteria outlined in the Case Management Services manual chapter, <del>state rule</del> LAC Title XXI, and the SW Provider Manual.	<u>Provider Type 45:</u> <u>Case Management</u>
<u>Center-Based Respite</u>	<del>Home and Community Based Services</del> HCBS Provider License Respite Care Module for a facility	<u>Provider Type 83:</u> <u>Respite</u>
<u>In-Home Respite</u>	N/A	<u>Provider Type 82:</u> <u>Attendant Care Services</u>
<u>Personal Emergency Response Systems</u>	Must meet all applicable vendor requirements, federal, state, parish and local laws for installation.	<u>Provider Type 16:</u> <u>Personal Emergency Response Systems</u>
<u>Habilitation</u>	<del>Home and Community Based Services</del> HCBS Provider License	<u>Provider Type 82, 98, 14 or 13:</u>
<u>Dental</u>	Current and valid Louisiana license to practice in the field of expertise/specialty	<u>Provider 27:</u> <u>Dental-Individual or Group</u>

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Waiver Service	Requirements	Service Provided by
<u>Individual Supported Employment</u>	<u>Employment Specialist</u> has a certification from an approved vendor in a 40 hour supported employment program with 20 hours of employment related training every <del>two</del> years	<u>Provider Type 98: Individual Supported Employment</u>
<u>Group Supported Employment</u>	Employment specialist has a certification from an approved vendor in a 40 hour supported employment program with 20 hours of employment related training every <del>two</del> years OR <del>Home and Community Based Services</del> HCBS Provider license with Adult Day Care (ADC) Module and Employment specialist has a certification from an approved vendor in a 40 hour supported employment program with 20 hours of employment related training every <del>two</del> years	<u>Provider Type 98: Group Supported Employment</u>
<u>Onsite Prevocational Services/Community Career Planning</u>	<del>Home and Community Based Services</del> HCBS Provider License ( <del>ADC Adult Day Care</del> Module)	<u>Provider Type 13: Prevocational Habilitation</u>
<u>Onsite Day Habilitation/Community Life Engagement</u>	<del>Home and Community Based Services</del> HCBS Provider License ( <del>ADC Adult Day Care</del> Module)	<u>Provider Type 14: Adult Day Habilitation</u>

When required by state law, the person performing the service, must meet all applicable requirements for professional licensure.

**Provider Responsibilities for All Providers**

All providers of ~~Supports Waiver~~ SW services are responsible for the following:

- Ensuring an appropriate representative from the agency attends the POC planning meeting and is an active participant in the team meeting;

NOTE: An appropriate representative is considered to be someone who has knowledge and authority to make decisions about the beneficiary's service delivery. This person may be a program manager, a direct services professional.

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case supervisor, or the executive director or designee. An unlicensed direct service worker who works with or will work with the beneficiary is not considered an appropriate representative for the POC planning meeting.

2. Communicating and working with support coordinators and other support team members to achieve the beneficiary's personal outcomes;
- ~~3.~~ 3. Ensuring the provider plan of care documents/attachments are updated and kept current as changes occur, including the beneficiary's emergency contact information and list of current medications;
4. Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or timelines in the POC will not meet the beneficiary's needs, and such information must be provided no later than ten (10) days prior to the expiration of any timelines in the service plan that cannot be met;
5. An update to the provider's document should only occur as a result of a documented meeting with the beneficiary or authorized representative where the reason for change is indicated and all parties sign the meeting attendance record;
6. Ensuring the provider agency support team member(s) sign and date any revisions to the service plan indicating agreement with the changes to the goals, objectives, or timelines;
7. Providing the support coordination agency or LDH representatives with requested written documentation, including, but not limited to:
  - a. Completed, signed, and dated POC attachment;
  - b. Service logs, progress notes, and progress summaries;
  - c. Direct service worker (DSW) attendance and payroll records;
  - d. Written grievances or complaints filed by beneficiaries/family;
  - e. Critical or other incident reports involving the beneficiary; and
  - f. Entrance and exit interview documentation.



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8. Explaining to the beneficiary/beneficiary’s family in his/her native language, the beneficiary rights and responsibilities within the agency; and
9. Ensuring that beneficiaries are free to make a choice of providers without undue influence.

Note: It is the policy of the Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD) that all critical incidents for ~~Home and Community Based Services (HCBS)~~ be reported, investigated and tracked. The statewide incident management system **MUST** be used for **ALL** critical incident reporting.

Support Coordination

Support coordination is a service that will assist beneficiaries in gaining access to all of their needed support services, including medical, social, educational, and other services, regardless of the funding source for the services.

Support Coordination Providers

Providers of support coordination for the SW program must have a signed performance agreement with OCDD to provide services to waiver beneficiaries. ~~Support coordination agencies~~SCAs must meet all of the performance agreement requirements in addition to any additional criteria outlined by OCDD.

Support Coordination activities include, but are not limited to, the following:

1. Assisting the beneficiary in coordinating and convening the person-centered planning team for the annual POC and/or as needed. Supporting the beneficiary to lead the meeting, which should include those who the beneficiary chooses to participate in the meeting. Those might include, but are not limited to, the beneficiary’s family, friends, direct service provider(s), including the day and/or employment provider, employer (if applicable), medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies needed in order to meet the beneficiary’s needs and preferences;
2. Support coordinator (SC) should participate in training regarding employment and assisting the beneficiary with obtaining employment;

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3. Complete a quarterly discussion around employment and the career path with each beneficiary who wants to work;
4. Offer freedom of choice of providers and settings, to include non-disability specific settings to each beneficiary;
5. On-going coordination and monitoring of supports and services included in the beneficiary's approved POC;
6. Building and implementing the supports and services as described in the POC;
7. Assisting the beneficiary to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the beneficiary in the POC;
8. Providing information to the beneficiary on potential community resources, including formal resources and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining his/her desired personal outcomes;
9. Assisting with coordinating transportation so that the beneficiary may have access to medical services, community resources and their job;
10. Assisting the beneficiary, families, services providers, and/or the LGE with the problem solving;
11. Assisting the beneficiary to initiate, develop, and maintain informal and natural support networks and to obtain the services identified in the POC, assuring that they meet their individual needs;
12. Advocating on behalf of the beneficiary to assist him or her in obtaining benefits, supports or services (i.e., to help establish, expand, maintain, and strengthen the beneficiary's information and natural support networks). This may involve calling and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary;
13. Training and supporting the beneficiary in self-advocacy (i.e., the selection of providers and utilization of community resources to achieve and maintain his/her desired outcomes);

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14. Oversight of the service providers to ensure that the beneficiary receives appropriate services and outcomes as designated in the POC;
15. Assisting the beneficiary to overcome obstacles, recognize potential opportunities, and develop creative opportunities;
- ~~16.~~ Meeting with the beneficiary in face-to-face meetings, as well as via telephone contact, as specified. This includes meeting the beneficiary where the services take place. The initial and annual ~~Plan of Care~~ POC meetings are to be done in a face-to-face meeting, preferably in the home, and at least one other meeting during the POC year must be done in a face-to-face manner;
17. Make the determination, using the guidelines provided, to determine if the beneficiary meets the criteria for virtual visits. If the criteria is met, the additional two meetings may be completed virtually, using an allowed source. The meeting may not be conducted telephonically and must be done where the individual and the home may be observed;
18. Reporting and documenting any incidents, complaints, abuse, and/or neglect according to the OCDD policy and in accordance with licensure, state laws, rules, and regulations, as applicable;
19. Arranging any necessary professional/clinical evaluations needed and ensuring beneficiary choice;
20. Identifying, gathering, and reviewing the array of formal assessments and other documents that are relevant to the beneficiary's needs, interests, strengths, preferences, and desired personal outcomes;
21. Developing an action plan in conjunction with the beneficiary to monitor and evaluate strategies to ensure continued progress toward the beneficiary's personal outcomes; and
22. On-going discussions with the beneficiary, if they are of working age, about employment including;

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- a. Identifying barriers to employment and working to overcome those barriers, connecting the beneficiary to certified work incentive coordinators (CWIC) to do benefits planning;
- b. Assisting the beneficiary in the reporting of income to social security;
- c. Assisting the beneficiary in setting up an Achieving a Better Life Experience (ABLE) account;
- d. Referring the beneficiary to Louisiana Rehabilitation Services (LRS);
- e. Following the case through closure with LRS; and
- f. Other activities in the employment process may be identified, including the quarterly completion of data input using the Path to Employment Form.

**NOTE:** Advocacy is defined as assuring that the beneficiary receives appropriate supports and services of high quality and locating additional services not readily available in the community.

**Support Coordination Providers Qualifications**

Support coordination providers must meet the following requirements:

- 1. Must be licensed as a support coordination provider; and
- 2. Meet all requirements as outlined in the *Support Coordination Performance Agreement*.

**NOTE:** Please refer to the Guidelines for Support Planning, Operational Instruction for Critical Incident Review, and OCDD Support Coordination Reference Guide for additional information.

**Provider Responsibilities for All Residential Care Service Providers**

Direct service provider agencies must have written policy and procedure manuals that include, but are not limited to, provisions that govern the following:

- 1. Training policy that includes orientation and staff training requirements according to the ~~Home and Community Based Service~~ HCBS Providers Licensing Standards.

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- the ~~Direct Service Worker~~ DSW Registry, and the Class A Child Placing Licensing Standards (as applicable to specific residential service being provided);
2. Direct care abilities, skills, and knowledge requirements that employees must possess in order to adequately perform care and assistance as required by waiver beneficiaries;
  3. Employment and personnel job descriptions, hiring practices that include a policy against discrimination, employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances, staffing, and staff coverage plan;
  4. Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal;
  5. Identification, notification, and protection of beneficiary's rights, both verbally and in writing, in a language that the beneficiary/beneficiary's family is able to understand;
  6. Written grievance procedures;
  7. Information about abuse and neglect as defined by LDH regulations and state and federal laws;
  8. Electronic ~~V~~visit ~~V~~erification (E~~V~~V): requirement for proper use of check in/out; acceptable editing of electronically captured services; reporting services when in "no service zones" or failure to clock in/out (Electronic Connectivity ~~F~~orm and manual entry); confidentiality of log in information; monitoring of EVV system for proper use;
  9. ~~Direct Service Worker (DSW) Registry; requirement for accessing the Department's Adverse Action database for findings placed against the direct service workers prohibiting employment;~~
  10. Criminal ~~H~~istory ~~C~~hecks: requirement for compliance with state statutes for non-licensed direct care personnel; and
  11. ~~Direct Support Worker~~ DSW Wage floor: requirement for provider agencies to follow the ~~Direct Support Worker~~ DSW Wage floor established by Louisiana Medicaid and pay the DSWs as directed. The current wage floor can be found in the ~~Louisiana Administrative Code~~ LAC and OCDD will post a memo on their

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website (<https://ldh.la.gov/subhome/11>) and providers will be responsible for following this directive.

**POC Provider Documents**

The direct service provider must complete the provider attachments that are a part of the POC, to include all waiver services that the agency provides to the beneficiary based on the beneficiary's identified POC goals and other supports required.

The provider documents in the POC must be person-centered, focused on the beneficiary's desired outcomes, and include the following elements:

1. Specific goals matching the goals outlined in the beneficiary's approved POC;
2. Measurable objectives and timelines to meet the specified goals, and strategies to meet the objectives;
3. Identification of the direct service provider staff and any other support team members who will be involved in implementing the strategies; and
4. The method that will be used to document and measure the implementation of specified goals and objectives.

The POC provider documents must be reviewed and updated, as necessary, to comply with the specified goals, objectives, and timelines stated in the beneficiary's approved POC or when changes are necessary based on beneficiary needs.

**Back-up Planning**

Direct service providers are responsible for providing all necessary staff to fulfill the health and welfare needs of the beneficiary when paid supports are scheduled to be provided. This includes during times when the scheduled direct service worker is absent or is unavailable or unable to work for any reason.

All direct service providers are required to develop an individualized back-up plan for each beneficiary that includes detailed strategies and person-specific information that addresses the specialized care and supports needed by the beneficiary.

Direct service providers are required to:

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1. Have policies in place which outline the protocols that the agency has established to ensure that back-up direct service workers are readily available;
2. Ensure that lines of communication and chain of command procedures have been established; and
3. Have procedures for dissemination of the back-up plan information to beneficiaries, their authorized representatives, and their support coordinators.

Protocols must also describe how and when the direct support staff will be trained in the care needed by the beneficiary. This training must occur prior to any direct support staff member being solely responsible for a beneficiary.

Back-up plans must be updated as changes occur and, at a minimum, on an annual basis to ensure that the information is kept current and applicable to the beneficiary's needs. The back-up plan must be submitted to the beneficiary's support coordinator in a timely manner to be included as a component of the beneficiary's initial and annual POC.

Direct service providers may not use the beneficiary's informal support system as a means of meeting the agency's individualized back-up plan and/or emergency evacuation response plan requirements without documented consent of the informal support system. The beneficiary's family members and others identified in the beneficiary's circle of support may elect to provide back-up, but this does not exempt the provider from the requirement of providing the necessary staff for back-up purposes when paid supports are scheduled.

**Emergency Evacuation Planning**

Emergency evacuation plans must be developed in addition to the beneficiary's individualized back-up plan. Providers must have an emergency evacuation plan that specifies in detail how the direct service provider will respond to potential emergency situations such as fires, hurricanes, tropical storms, hazardous material release, flash flooding, ice storms, and terrorist attacks.

The emergency evacuation plan must be person-specific and include at a minimum the following components:

1. Individualized risk assessment of potential health emergencies;
2. A detailed plan to address the beneficiary's individualized evacuation needs, including a review of the beneficiary's individualized back-up plan, during

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geographical and natural disaster emergencies and all other potential emergency conditions;

3. Policies and procedures outlining the agency's implementation of emergency evacuation plans and the coordination of these plans with the local Office of Emergency Preparedness and Homeland Security;
4. Establishment of effective lines of communication and chain of command procedures;
5. Establishment of procedures for the dissemination of the emergency evacuation plan to beneficiaries and support coordinators; and
6. Protocols outlining how and when direct service workers and beneficiaries will be trained in the implementation of the emergency evacuation plan and post-emergency procedures.

Training for direct service workers and surety of competency must occur prior to the worker being solely responsible for the support of the beneficiary.

The beneficiary must be provided with regular, planned opportunities to practice the emergency evacuation response plan.

OCDD, support coordination agencies, and direct service provider agencies are responsible for following the established emergency protocol before, during, and after hurricanes or other natural disasters or events as outlined in the "Emergency Protocol for Tracking Location Before, During, and After Hurricanes" document found in the OCDD Guidelines for Support Planning manual. (Refer to Appendix D of this manual chapter for website information).

**Day Habilitation Provider Responsibilities**

The providers who provide Day Habilitation services must possess a current, valid ~~Home and Community Based Service~~HCBS Provider ~~ADC Adult Day Care~~ License to provide day habilitation/community life engagement services and must adhere to the following requirements in order to provide transportation to beneficiaries:

1. Vehicles used in transporting beneficiaries must adhere to the requirements of the HCBS licensing rule;
2. Drivers must have a valid, current Louisiana driver's license that is applicable to



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the vehicle being used;

3. The provider must document this service in the beneficiary's record, and the trip must be documented in the provider's transportation log, which can be either electronic with GPS tracking or a paper log; and

NOTE: The log is not required to be filed in the beneficiary's record file, but must contain information that identifies the beneficiary, the time of pick up, and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including LGE and Support Coordination.

4. Vehicles used in transporting beneficiaries must:

- a. Be in good condition and repair;
- b. Have a current Louisiana inspection sticker; and
- c. Have a first aid kit on board.

### Supported Employment Provider Responsibilities

Supported ~~BE~~ employment providers must maintain documentation in the file of each individual beneficiary that the services are not available to the beneficiary 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 (26) and (29).], if available. LRS does not fund group employment, only individual employment. Therefore, if an individual is seeking group employment, this does not apply.

The employment specialist must possess a current certification from an accepted Supported Employment training program and the continuing education hours required (20 every ~~2~~two years). The provider may also have a valid ~~Home and Community Based Service~~HCBS Provider ~~ADCAdult Day Care~~ license, but this is not a requirement to provide supported employment services in the community.

Supported Employment providers who have an ADC license must adhere to the following requirements in order to provide transportation to beneficiaries:

1. Vehicles used in transporting beneficiaries must adhere to the requirements of the HCBS licensing rule;

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2. Drivers must have a valid, current Louisiana driver’s license applicable to the vehicle being used;

3. The provider must document this service in the beneficiary’s record, and the trip must be documented in the provider’s transportation log, which can be either electronic with GPS tracking or a paper log; and

NOTE: The log is not required to be filed in the beneficiary’s record file, but must contain information that identifies the beneficiary, the time of pick up, and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including LGE and Support Coordination.

4. Vehicles used in transporting beneficiaries must:

- a. Be in good condition and repair;
- b. Have a current Louisiana inspection sticker; and
- c. Have a first aid kit on board.

Providers must have a documented quarterly discussion with individuals who are working in group employment or individual employment.

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The discussion should include the following:

- 1. Is the individual happy with the current job?
- 2. Is the individual interested in additional hours or advancement on the job?

In addition to these questions, if the individual is working in group employment:

- 1. Is the individual interested in finding individual employment in the community?
- 2. Is the individual interested in career planning services?
- 3. Is the individual interested in additional hours or advancement?

Prevocational Provider Responsibilities

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The provider must maintain documentation in the file of each individual beneficiary receiving Prevocational services that the services are not available to eligible beneficiaries 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 (26) and (29)], if available.

The service provider must adhere to the following requirements in order to provide transportation to beneficiaries:

1. Vehicles used in transporting beneficiaries must adhere to the requirements of the HCBS licensing rule;
2. Drivers must have a valid, current Louisiana driver's license that is applicable to the vehicle being used;
3. The provider must document this service in the beneficiary's record, and the trip must be documented in the provider's transportation log; and
4. The vehicles used in transporting beneficiaries must:
  - a. Be in good condition and repair;
  - b. Have a current Louisiana inspection sticker; and
  - a-c. Have a first aid kit on board.

Providers should review the progress made on the Individual Career Planning (ICP) Profile on a quarterly basis. The provider must have a documented quarterly discussion with individuals who are in this service to include the following:

1. Review of the ICP Profile and the progress made thus far;
2. Is the individual still interested in finding employment;
3. Potential employment opportunities in the community; and
4. Ensure the individual is still interested in career planning services.