Developmental Services

Case Management Manual



State of Maine

Office of Aging and Disability Services

# Section I: Case Management Overview

## Introduction

The Office of Aging and Disability Services (OADS) provides leadership and is an active partner in Maine’s comprehensive system of supports to eligible adults with intellectual disabilities and Autism. At the foundation of this system is the belief that all individuals, through self-determination, can achieve a quality of life consistent with the community in which he/she lives. Supports will be flexible and designed in a manner that recognizes people’s changing needs throughout their lifetimes.

## Developmental Services Vision and Values

OADS’s Vision and Values is a roadmap for services and supports for persons with intellectual disabilities and Autism. Its guiding principles are that services:

* Be centered on the person and focus on strengths and abilities.
* Support each person to make their own informed choices.
* Promote respect of adults and their valued roles within their community.
* Provide opportunities for quality employment that pays a fair wage and benefits.
* Maximize opportunities for independence and self-sufficiency.
* Provide quality case management services including conflict free Person Centered Planning.
* Support and encourage family, friends, and neighbors to help meet the individual’s needs.
* Ensure health and safety while promoting choices for new growth and development.
* Build a coordinated, streamlined service and support system using resources wisely.

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**Definitions**

**Abuse** is the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; or the intentional, knowing or reckless deprivation of essential needs. Abuse includes acts and omissions.

**Acquired brain injury** is an insult to the brain resulting directly or indirectly from trauma, anoxia, vascular lesions or infection, which:

* Is not of a degenerative or congenital nature;
* Can produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities or physical functioning;
* Can result in the disturbance of behavioral or emotional function;
* Can be either temporary or permanent; and
* Can cause partial or total functional disability or psychosocial maladjustment.

**Adult** is any individual who has attained the age of 18 or who is a legally emancipated minor.

**Adult Protective Services** is a unit within the Office of Aging and Disability Services (OADS) which is authorized to investigate abuse, neglect, and exploitation.

**At risk** means a situation in which physical or mental injury, physical or mental impairment, physical pain, or mental anguish is likely to occur.

**Autism** is a developmental disorder characterized by a lack of responsiveness to other people, gross impairment in communicative skills and unusual responses to various aspects of the environment as defined at 34-B M.R.S.A. §6002 and DHHS rule 14-197 Chapter 3 (3.2).

**Case Manager** is a person responsible for assuring the timely convening of the service planning team, developing the Personal Plan, monitoring the planned services received by the participant, and for ensuring that those services meet the requirements set forth in the participant’s Personal Plan.

**Case Management Services** are those covered services provided by a social service, health professional, or other qualified staff, to identify the medical, social, educational and other needs (including housing and transportation) of the eligible participant, identify the services necessary to meet those needs, and facilitate access to those services. Case management consists of intake/assessment, plan of care development, coordination and advocacy, monitoring, and evaluation. (As defined in MaineCare Benefits Manual Section 13.01-5).

**Commissioner** is the Commissioner of the Department of Health and Human Services.

**Community Inclusion** enables participants to become active citizens in their communities based on interests that promote building relationships in everyday, ordinary places. Community Inclusion is not a center-based service but support provided to a participant to assist in navigating his/her community in the company of non-paid community members.

**Conservatorship** is a fiduciary relationship created by court appointment of a conservator, pursuant to the Maine Probate Code, 18-A M.R.S.A. §5-401 et seq. or 18-A M.R.S.A. §5-601 et seq., to manage the financial affairs of a protected individual based upon a finding of inability of the protected individual to manage their property and affairs.

**Correspondent** is a person designated by the Maine Oversight and Advisory Board or its successor to act as a next friend of a person with an Intellectual Disability or Autism.

**Crisis** is any incident, behavior, activity, or pattern of activity, which could lead to the loss of a person's residence, program, or employment.

**Crisis Intervention Services** are direct intensive supports provided to participants who are experiencing a psychological, behavioral, or emotional crisis. The scope, intensity, duration, intent and outcome of Crisis Intervention must be documented in the Personal Plan. Crisis Intervention is commonly provided on a short-term intermittent basis.(Refer to MaineCare Benefit Manual Section 21.05-12 for requirements as a covered service).

**Deafness** is a condition in which a person's sense of hearing is nonfunctional for the purpose of hearing and understanding spoken communication with or without hearing aids. Communication must occur through visual and/or tactile means or through an implant. Persons with a hearing loss in the severe and profound ranges typically fall under this definition.

**Department** is the Department of Health and Human Services (DHHS).

**Dependent Adult** is one who has a physical or mental condition that substantially impairs the adult’s ability to adequately provide for that adult’s daily needs.

**Direct Support Professional** (DSP) is a person who provides Home Support, Work Support, Community Support, or Crisis Intervention to participants with an Intellectual Disability or autism. DSP’s must meet the Provider Qualifications and Requirements as specified in MaineCare Benefits Manual Section 21.10-1 and Section29.10-1. All new staff and subcontractors must obtain DSP certification or demonstrate proficiency through DHHS’s approved Assessment of Prior Learning.

**Developmental Services** of the Department of Health and Human Services’ Office of Aging and Disability Services (OADS) serves eligible adults with an Intellectual Disability or Autism.

**Disability Rights Center** (DRC) provides advocacy services to Maine citizens with a disability who need help with a problem related to their disability.

**Emergency** is a situation, physical condition, financial condition or one or more practices, methods or operations that present imminent danger of death or serious physical or mental harm to individuals served or funded by the Department, including, but not limited to, imminent or actual abandonment by a facility or of a service.

**Enterprise Information System (EIS)** is a DHHS data management information system.

**Exploitation** means the illegal or improper use of an incapacitated or dependent adult or that adult's resources for another's profit or advantage.

**Guardian** is a person(s) or agency with ongoing legal responsibility for ensuring the care of an individual, appointed pursuant to 18-A M.R.S.A. §5-301 et seq. and for Public Guardian 18-A M.R.S.A.§5-601 et seq..

**Hard-of-Hearing,** or Hearing Impaired, describes an impairment in hearing, whether permanent or fluctuating, that adversely affects a person’s ability to hear and understand spoken language. Individuals that typically fall under this definition primarily have hearing loss in the mild to moderate range or a conductive hearing loss.

**HIPAA** is the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191).

**Incapacitated Adult** is any adult who is impaired by reason of mental illness, mental deficiency, physical illness or disability to the extent that the individual lacks sufficient understanding or capacity to make or communicate responsible decisions concerning that individual’s person, or to the extent the adult cannot effectively manage or apply that individual’s estate to necessary ends. (APS Act, 22 M.R.S.A. §3472 [10]).

**Informed Consent** is a decision made with all relevant information about the issue, with an understanding of the consequences of a decision, without any element of force, fraud, deceit, duress or other form of constraint or coercion.

**Intellectual Disability** means a condition of significantly sub-average intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period. [Title 34B M.R.S.A. §5001(3)](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5001.html)

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)** means an institution (or distinct part of an institution) that is 1.) Primarily for the diagnosis, treatment, or rehabilitation of the intellectually disabled or persons with related conditions; and 2.) Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability. (42 CFR 435.1009)

**Interpreter** is a neutral bilingual, bicultural third party fluent in both English and the target language, trained to convey communications between two or more parties who do not share a common language. See MaineCare Benefits Manual Section1.06-3: Interpreter Services.

**Intake** describes the period during which a person who has been referred for services is assessed to determine eligibility for Development Services.

**Intake Worker** is the DHHS staff member assigned responsibility for completion of the intake process.

**Natural Supports** are the people associated with the setting of the participant. They include unpaid relationships with family members, friends, co-workers, neighbors and acquaintances and are of a reciprocal nature. Such supports promote valued roles within one’s community and maximize opportunities for independence and self-sufficiency.

**Neglect** is a threat to an adult’s health or welfare by physical or mental injury or impairment, deprivation of essential needs, or lack of protection from these.

**Participant** is a person applying for or receiving Developmental Services supports and /or services, or the person for whom those services are requested.

**Preadmission Screening and Resident Review** (PASRR) is a program to ensure that persons who are otherwise eligible for care in a nursing facility and who also have a mental illness, developmental disability, or Other Related Conditions as defined in Maine Statute receive the additional care necessary to meet those needs.

**Person Centered Planning** (PCP) is the planning process for adults receiving Developmental Services in Maine which involves identifying and describing the participant’s needs, desires, goals and support services to live a meaningful and self-directed life.

**Personal Plan** is based on a comprehensive assessment, which must address all identified needs and desires of a Participant. The Personal Plan is individualized, and includes personal goals that the Participant wants to achieve. Other terms for the Personal Plan include Plan of Care, Individual Personal Plan, Individualized Support Plan, Individualized Educational Plan, and Service Plan. The Personal Plan must be developed at least annually and includes covered and non-covered services.

**Public Guardian** is a representative of DHHS when appointed as such by a Court pursuant to 18-A M.R.S.A. **§** 5-601 et seq.

**Reportable Events** are events that have, or may have, an adverse impact upon the safety, welfare, rights or dignity of adults with intellectual disabilities or autism.

**Representative Payee** provides financial management for beneficiaries of Social Security and SSI payments who are incapable of managing their Social Security or SSI payments. A Representative Payee’s responsibilities include: using benefits to pay for the current and foreseeable needs of the beneficiaries; appropriately saving any remaining benefits; and keeping good records of how benefits are spent. The Social Security Administration assigns individuals/organizations that assist beneficiaries in managing benefits through their Representative Payee Program.

**Visual Gestural Communication** (VGC) is a communication mode that is based on gesture including self-created signs and signs from a formal sign language but that does not include a grammar system governing how words are put together into sentences as would a formal sign language. The State of Maine recognizes VGC as a communication form and includes therapeutic services in its array of comprehensive waiver services.

**Ward** is a person for whom a Guardian has been appointed under Title 18-A, **§**5.101, Article V, Part 6.

## Case Management Services

Case Management is a MaineCare covered service provided by a social service, health professional, or other qualified staff to identify the medical, social, educational and other needs (including housing and transportation) of the eligible member, identify the services necessary to meet those needs, and facilitate access to those services. Case management consists of intake, assessment/eligibility, plan of care development, coordination and advocacy, monitoring, and evaluation.Refer to MaineCare Benefits Manual, [Section 13: Targeted Case Management](http://www.maine.gov/sos/cec/rules/10/ch101.htm)for adescription of MaineCare covered services for Case Management Services.

Case Management Services include:

### Intake

### Intake is the process in which an applicant establishes a formal relationship with Developmental Services. Participants are considered to be in an intake status until eligibility for Developmental Services is determined. OADS is responsible for intake and eligibility determinations.

### Assessment/Eligibility

### The process for determining eligibility for Developmental Services is at [M.R.S.A. Title 34-B Section §5467](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5467.html): Application and Preliminary Procedures. An individual must be age eighteen (18) or older and meet the eligibility requirements for an Intellectual Disability or Autism. Intellectual Disability is defined in [M.R.S.A. Title 34-B § 5001](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5001.html) and [DHHS Rule 14 – 197 Chapter 3 (3.1**)**](http://www.maine.gov/sos/cec/rules/10/chaps10.htm#197)**.** Autism is defined in [M.R.S.A. Title 34-B § 6002](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec6002.html) and [DHHS Rule 14 – 197 Chapter 3 (3.2)](http://www.maine.gov/sos/cec/rules/10/chaps10.htm#197). [DHHS Rule 14 – 197 Chapter 3 (3.1) and (3.2)](http://www.maine.gov/sos/cec/rules/10/chaps10.htm#197) describes the assessment tools and processes used to determine eligibility for Developmental Services. This rule also describes applicants’ rights to appeal eligibility decisions.

Once eligibility is determined, the Participant is given the choice of a case management service provider which is through either OADS or a community agency. Choice may be limited by case load ratios. Adults under full Public Guardianship will receive Case Management Services through OADS. A Participant who has reached his or her 18th birthday and is under age 21 may continue to receive Children’s case management services or may choose to receive adult Case Management Services.

The MaineCare Benefits Manual ([Section 13: Targeted Case Management](http://www.maine.gov/sos/cec/rules/10/ch101.htm), §13.03-4: Eligibility for Targeted Case Management) describes targeted population groups’ eligibility for Case Management Services including for adults with developmental disabilities.

Refer to Section V: MaineCare Services for descriptions of the services available under MaineCare for Participants with an Intellectual Disability or Autism.

### Personal Plan Development

### [M.R.S.A. 34B Section 5470-A](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5470-B.html) identifies the rights of adults with an Intellectual Disability or Autism, eligible for services, to engage in a personal planning process in which the needs and desires of the person are articulated and identified. Person-Centered Planning (PCP) is the planning process for adults receiving Developmental Services. The phases of the planning process are: Process Coordination (Parts I and II), Service Planning, and Personal Planning. Person-Centered Planning is an annual process in which the Participant’s goals are identified without regard to whether a Participant’s desires are reasonably achievable or the resources necessary to meet a goal are available.

### The Person-Centered Planning process is designed to promote respect of a Participant’s goals and desires and valued roles within the community. When Person-Centered Planning works, people have enhanced opportunities to make personal choices and experience self-sufficiency. The Person-Centered Planning process also meets regulatory requirements, provides a method for resource allocation, communicates changes in a Participant’s status, and ensures consistency and accountability in the delivery of services.

### The Person-Centered Planning process results in a written service plan that collects information for approval of and implementation of the Personal Plan, authorization of MaineCare services, and is subject to review by quality assurance.

### The *Person-Centered Planning Process for Persons with Intellectual Disabilities and Autism: Instruction Manual* contains detailed instructions and forms for completing the Personal Plan and the PCP planning process. Refer to [Person-Centered Planning Process Instruction Manual](http://www.maine.gov/dhhs/oads/disability/ds/pcp-action-plan/PDF/PCP%20Manual7-31-13.pdf)**.**

### Coordination and Advocacy

### These activities are for the purpose of linking the Participant with medical, social, educational, or vocational providers and other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the Personal Plan. This includes promoting health and wellness, community inclusion, and identifying information and referral resources.

When necessary and indicated, coordination activities may include arranging activities designed to promote, support and maintain the Participant’s health and wellness. This may include:

* Medical and dental exams and treatments.
* Mental health treatment and services.
* Nutritional/physical activity support.
* Occupational, Physical and Speech Therapy.
* Acquisition and use of needed medical equipment.
* Management of chronic illnesses and conditions.

Necessary and indicated refers to activities identified and documented as such in the Personal Plan, and which the Participant will require assistance with in order to achieve.

Community Inclusion activities connect Participants to their community. This includes support for developing and enhancing relationships that promote social roles such as volunteering; accessing community, sporting, business or community events or resources; and acquiring skills that promote independence. Community Inclusion assists the Participant in locating and connecting to natural supports in the community that enhance the Participant’s vision for a desired life. Services may include assistance and coordination with:

* Identifying community groups, agencies and organizations that reflect the Participant’s personal interests (ie churches, Weight Watchers, hiking clubs).
* Arranging volunteer opportunities and activities.
* Locating support groups or self-help activities.
* Coordinating or arranging instruction, guidance, modeling, or mentoring through community groups, agencies or civic organizations.
* Coordinating or arranging supports necessary to participate in community events.
* Assisting, coordinating, and facilitating connections to sources of support through families, friends, allies or community or civic organizations.

Information and Referral includes researching and identifying resources that assist Participants to access and secure:

* State and federal benefits to which a Participant is entitled (ie MaineCare, (Medicaid), Medicare, SSI, housing assistance, community support services, prescription drug programs, general assistance, employment services, vocational supports, and educational supports).
* Medical, dental and/or mental health services.
* Providing information on local resources and how to use such as public transportation, libraries, or adult education classes.
* Membership in local support or self-help groups to promote Community Inclusion i.e. Speaking Up for Us (SUFU).
* Opportunities for Community Inclusion i.e. YMCA, concerts, or sporting events.
* Information that assists the Participant to understand the support system, including rights, responsibilities, grievance and appeal options and the decision-making process.
* Information about services and provider options so that decisions about services are based on informed choices.

### Monitoring

### Case Managers are required to monitor Participants’ assessed needs (including health and safety risk factors) and personal goals. Case Managers must also have periodic contact with the guardian and family members as appropriate, who are identified in the Personal Plan. Contact with providers and other entities is required as part of the monitoring process. The Case Manager must also ensure compliance with reporting requirements of MaineCare, and other funding and regulatory authorities by completing documentation and reports.

### Contact with Participants should occur in a variety of settings including the home, community support program and work setting. Documentation should indicate the setting in which the Participant is seen. Monitoring activities include:

* Identification and mediation of issues that may arise with housing, employment, community membership, or day support services.
* Engaging directly with the Participant to avoid or resolve a crisis or other challenging personal situation.
* Ensuring that the Participant is satisfied with services provided.
* Ensuring that Reportable Events reports are filed as required.

Monitoring includes ensuring that the individual Personal Plan is effectively implemented and adequately addresses the ongoing needs of the Participant. This includes that:

* Services are furnished in accordance with the Personal Plan.
* Services in the Personal Plan are adequate to address the needs of the Participant.
* That the Personal Plan is updated and service arrangements with providers are modified or terminated when a Participant’s needs or status has changed.

Monitoring is done through face-to-face contact and by phone calls with the Participant, guardian, family, support staff and natural supports. The frequency of this contact is determined by the Participant’s needs, requests, program requirements, and recommendations of the planning team made during the PCP process but monthly contact at a minimum is required. Face-to-face contact is preferred, but a phone call may be substituted when face-to-face contact is not possible. Refer to the Table: Requirements for Contact with Participants in Section III: Contacts for the requirements for frequency and methods of contact.

During the Case Manager’s contact with the Participant, focus includes the Participant’s:

* residential/community/employment supports, including unmet needs
* physical well-being
* emotional well-being
* social well-being
* environment (home and work)
* communication with staff, family and peers

### Evaluation

### Review by the Case Manager of the Personal Plan must occur at a minimum of not more than every ninety (90) days or as changes in the Participant’s needs occur. A Participant can decline services identified in the Personal Plan, but this must be documented in EIS.

### OADS conducts quality assurance activities to ensure that services to adults with an Intellectual Disability or Autism are delivered as intended, to assess the overall quality of services and supports, identify system and individual improvements, and to meet regulatory requirements.

### Service Providers also conduct quality assurance activities to meet contractual obligations for MaineCare and to ensure that services are provided in accordance with policies and procedures.

### Periodically, Case Managers will conduct quality assurance activities including reviewing findings and implementing improvements to address quality assurance or quality improvement objectives.

## Professional Boundaries

Case Managers should be aware of the potential influence and perceived authority of their position on Participants and take steps to ensure that professional boundaries are maintained. Case Managers must adhere to the roles and expectations of the job description and should adhere to the ethical requirements of their professional licensing.

Contact with Participants should be limited to those that are assigned to the Case Manager while employed as a Case Manager and occur during regular working hours. Any planned interaction outside of the regular working relationship and/or scheduled work time must be authorized by a Supervisor. Concerns about a co-worker exceeding professional boundaries must be reported to a Supervisor.

Case Managers must not give or accept gifts or other items to or from Participants.

# Section II: Legal

## Emergency Interventions and Behavioral Treatment

[Title 14-197 Chapter 5](http://www.maine.gov/sos/cec/rules/14/197/197c008.doc) governs behavioral treatment procedures for persons with an Intellectual Disability or Autism. These rules address emergency interventions and the procedures that must be followed if intrusive behavioral interventions or any form of emergency restraint is used. Revisions to these rules are expected in 2014.

## Grievance Process

A grievance is a complaint about an action or inaction of the Department or about providers of services or supports, involving rights afforded by law or rules or about dissatisfaction with services or supports. Grievances include allegations of denial of services or supports relating to the PCP or other planning process.

The rule, Describing Grievance and Appeals Procedures for Persons with an Intellectual Disability, found in [Title 14 197 Chapter 8](http://www.maine.gov/sos/cec/rules/10/chaps10.htm), describes the process for resolving grievances once they are referred to the Department. Case Managers are responsible for ensuring that Participants and guardians, if appropriate, are aware of their grievance and appeal rights. Case Managers are also responsible for promptly addressing and documenting efforts to resolve a grievance according to the procedures contained in the rule. Refer to the rule for procedures and the required timelines for responding to grievances. Refer to [34-B M.R.S.A. §5604 (3)](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5604.html) for statutory protections of individuals with an Intellectual Disability or Autism. [Refer to OADS website for Grievance Process Forms and Information](http://www.maine.gov/dhhs/oads/disability/ds/grievance/home.html).

## Legal Protections

The table below identifies the responsibilities of Case Managers related to upholding key rights and legal protections contained in Maine Revised Statutes and OADS policies and procedures.

|  |  |
| --- | --- |
| [Title 34 B M.R.S.A. §5201.6](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bch5sec0.html) | Individual Support Coordinators (Case Management Services) |
| [Title 34 B §5470-B](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bch5sec0.html) | Personal Planning |
| [Title 22, Chapter 958-A: Adult Protective Services Act](http://www.mainelegislature.org/legis/statutes/22/title22ch958-Asec0.html) | Adult Protective Services Act   |
| [OADS website](http://www.maine.gov/dhhs/oads/disability/ds/grievance/home.html) | Grievance Process and MaineCare Appeal |
| [34 B M.R.S.A. § 7001-7016](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bch5sec0.html) | Due Process in Sterilization Act |
| [18\_A Section 5- 601 – 5.614](http://www.mainelegislature.org/legis/statutes/18-A/title18-Ach5sec0.html) | Protection of Persons Under Disability with Property |

## MaineCare Appeals

A person who has been notified of a reduction, termination, denial or suspension of MaineCare has the right to appeal this decision through an administrative hearing. The Appeal process that a Participant must follow is described in the MaineCare Benefit Manual, [Chapter 1 – Section 1 General Administrative Policies and Procedures § 1.22-1: Member Appeals](http://www.maine.gov/sos/cec/rules/10/ch101.htm) (page 73).

## Public Guardianship and Conservatorship

Public guardianship appointments are made to provide continuing care and supervision of incapacitated adults, and public conservatorship appointments are made to protect, preserve, manage and apply estates of incapacitated adults, when it has been determined that no suitable private guardian or conservator is available and willing to assume responsibilities for such service.

### Annual Court Report/Accountings

OADS Case Managers will review the status of a public Ward annually to determine if a public appointment continues to be necessary and desirable. The annual court report, filed with the Probate Court, is a review of the original Court plan and a summary of the Ward’s current status. The report will be shared with the Ward, or if not, an explanation as to why it is not given will be documented. The following areas are required to be addressed:

1. Examination and evaluation of the original Probate Court plan including current status.
2. Recommendation for modification of the plan for the Ward, as deemed appropriate or necessary. This includes statements as to whether a public appointment is necessary and desirable; whether there is a suitable private individual willing and able to serve: and if any limitations to the appointment may be indicated.
3. Financial status including sources of income, how income is used, balance in accounts, and mortuary trust information and amounts.

OADS Estate Management staff in Central Office will prepare and submit inventories and annual accountings to the Probate Court for adults under public Conservatorship.

### Levels of Authorization Delegated by the Commissioner

OADS Case Managers may make decisions on behalf of public wards and protected persons, except as otherwise provided in Maine statute and OADS policy. Refer to OADS policy [10-149 Ch. 5 Section 15.09: Adult Protective Services: Guardianship/Conservatorship, Levels of Authorization Delegated by the Commissioner](http://www.maine.gov/sos/cec/rules/10/149/149c5-15.doc). Authorizations will be consistent with the Probate Court appointment and within the appropriate scope of the Case Manager’s level of authority.

When the public appointment includes financial authority, OADS Case Managers are responsible for identifying assets and obligations of the Participant, and securing and using those assets for the benefit of the Participant. Refer to OADS website for [Estate and Financial Management procedures.](http://www.maine.gov/dhhs/oads/disability/ds/comm-cm/index.shtml)

### Motion for Change of Venue

Upon change of residence of the Ward or protected person, OADS Case Managers will determine if a motion for change of venue is appropriate and work with a Supervisor for assistance in completing the required documentation for the Probate Court.

## Reportable Events

The Reportable Events system enables providers of services including Case Managers to report certain events to OADS as required by state rule and by DHHS policy. The purpose of the Reportable Events system is to ensure that events that have or may have an adverse impact on the safety, welfare, rights or dignity of persons with intellectual disabilities or Autism are documented, reported, investigated and reviewed.

DHHS Rule [14-197 Chapter 12](http://www.maine.gov/sos/cec/rules/10/chaps10.htm#149):[[1]](#footnote-1) specifics the obligations of Case Managers, and other providers of services, to report certain events and specifies uniform procedures about:

* Who must report
* What must be reported
* Where to report
* When to report, including situations that require reports to be made immediately.

A single form is used to file all Reportable Events. The form and instructions are found on OADS’s website. Click [here](http://www.maine.gov/dhhs/oads/disability/ds/aps/procedures.htm) to get the forms. The Reportable Event form doesn’t replace the need to communicate with your Supervisor when an adverse event occurs.

A PowerPoint presentation on Reportable Events system can be found [here](http://www.maine.gov/dhhs/oads/disability/ds/aps/documents/reportable%20events.pdf).

DHHS Rule 14-197 Chapter 12 also contains procedures that the Adult Protective Services follows to investigate allegations of abuse, neglect, and exploitation of adults pursuant to the Adult Protective Services Act, 22 M.R.S.A. §3471 and 3473.

All alleged violations of the rights of a Participant pursuant to 34B M.R.S.A. 5606 sub-1 must be reported through the Reportable Events system.

The rights and basic protections that a person with an Intellectual Disability or Autism is entitled to are found in 34-B§5605. Clink [here](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5605.html) for these rights.

##

## Rights of Citizens with Intellectual Disabilities or Autism

Case Managers are responsible for safeguarding Participant’s rights and basic protections as promulgated in Title, 34B, § 5605: [Rights and Basic Protections of a Person with an Intellectual Disability or Autism](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5605.html). Case Manager’s responsibilities associated with ensuring Participant’s rights include that:

* Participants receive an explanation of their rights in understandable terms at intake.
* The Participant, or guardian if the Participant has been determined incapacitated by a Probate Court, receives a copy of these rights.
* Providers of services must post the Rights and Basic Protections of a Person with an Intellectual Disability or Autism (or the Plain Language Version).
* Participant’s rights are monitored through routine visits and contact with the Participant.
* Allegations of the denial of these rights are reported through the Department’s Reportable Events system.

## Sterilization Statutes

The [Due Process in Sterilization Act of 1982 (34 B M.R.S.A. §7001-7016)](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bch7sec0.html) recognizes the generally irreversible and highly significant consequences for the patient intended "to prevent indiscriminate and unnecessary sterilization, and to assure equal access to desired medical procedures for all Maine citizens.” The Act requires that a physician obtain Informed Consent prior to initiating sterilization procedures on any individual. A District Court hearing is required to determine ability to give informed consent for:

* Persons under 18 years of age and not married or otherwise emancipated.
* Persons presently under public or private guardianship or conservatorship.
* Persons residing in a state institution providing care, treatment or security; or
* Persons from whom a physician could not obtain Informed Consent.

Case Managers should not become involved in explaining to parents, Participants, or guardians the legal requirements for sterilization. If sterilization is being considered by a Participant, the case must be discussed with a Supervisor. Sterilization is a legal matter that can only be resolved by the District Court.

# Section III: Case Management Standards and Procedures

## Case Management Services for Persons without MaineCare

State Case Management Supervisors can assign a State Case Manager for individuals eligible for Developmental Services who are not MaineCare eligible. The State Case Manager will assist the person through the MaineCare application process. If the individual is determined eligible for MaineCare benefits then the Participant can choose a community case management agency for their Case Management Services.

## Changes in Participant Services

### Change of Case Management Agency

MaineCare Benefits Manual, Section 13.06 (1) Targeted Case Management (One Comprehensive Case Manager) requires that a Participant has only one Case Manager at a time. The sending and receiving Case Management Supervisors must determine which agency will bill for Case Management Services during the transfer period. The sending and receiving Case Management agency Supervisors must then ensure that updates are made in EIS.

Participants must be informed about available case management agencies and choose whom they receive services from. The Case Manager’s responsibility is to ensure that the participant has choice and that the discussions about options are documented as a General Note in EIS.

The Case Manager must obtain a signed [Authorization for Release of Information](http://www.maine.gov/dhhs/privacy/DHHS-AZ-11-22.pdf)form before any information is shared. If possible, a transfer meeting should occur between the Participant/or guardian and agencies involved.

This includes situations when the Participant:

* Is assigned to a community case management agency.
* Transfers from OADS to a community case management agency.
* Transfers from one OADS District to a different OADS District.

When a Participant transfers between two community case management agencies, the sending agency must assist the Participant in choosing another case management agency. These discussions and the options presented must be documented as a General Note in EIS.

The sending Case Management Supervisor then notifies the OADS Community Case Management Liaison so that the information about the Participant can be updated in EIS. When a Participant moves to another District, the Case Management Supervisor will also notify the current Resource Coordinator to ensure the transfer of financial information.

### Change/Transition from Children’s to Adult Services

A youth who has received DHHS services as a child may not qualify for DHHS programs or services that serve adults. It is crucial that the transition from Children’s to Adult services include joint planning to ensure the youth’s need for services such as housing, education, workforce and/or employment supports, medical care and monitoring, and community integration are addressed across the systems of care.

Youth must apply for, and meet the eligibility criteria of Developmental Services to receive services. This includes submitting an application, a comprehensive assessment and evaluation, and meeting the eligibility criteria of the program. A person must be 18 or older to receive adult Developmental Services. By statute, eligibility determination, which begins after the required documentation and evaluations are provided, can take up to 90 days.

For those youth who may qualify for mental health services and OADS (for example, has IQ test results in the 60’s to low 70’s, variable IQ test scores by history, and significant mental health concerns) it is recommended that a referral be made to both services.

### Change in Residential Setting

A change in housing/living situation can be initiated by the Participant or through the PCP planning process. The Case Manager should prepare the Participant for the move, assist the Participant in the transition to a new home and community, and monitor and evaluate the Participant’s adjustment to the new living situation. The Case Manager, in consultation with the Participant and support staff develops a transition plan to ensure a smooth transfer.

The following procedure is used when a change of residential setting need is identified:

1. The Case Manager fills out the Vendor Form and sends it to the Resource Coordinator (in the sending District).
2. The sending Resource Coordinator will confirm the Participant’s waiver status.
3. The sending Resource Coordinator will provide the receiving Resource Coordinator with transfer information.
4. The receiving Resource Coordinator will send out the Vendor Call to all qualified Vendors via email.
5. Interested Vendors will contact the sending Case Manager via email for more information about the Participant’s service needs.
6. The sending Case Manager must respond to residential placement offers made by Vendors by email within 10 days.
7. The sending Case Manager will arrange for the Participant to visit potential placement sites, if possible.

The following procedures are used when a Participant changes housing:

1. The Case Manager will notify the sending Resource Coordinator about the selected housing.
2. If possible, the sending Case Manager should arrange for the Participant to visit the selected housing.
3. The receiving Case Manager coordinates a post placement meeting within 30 days of the move into the selected housing.

### Transfer of Participant Records

The Case Manager will ensure that the Participant’s record is transferred as per the arrangements made between the sending and receiving Case Management Supervisors. This includes updating EIS with the new address and service agencies. The following documentation should be forwarded to the new case management agency.

* Psychological evaluations/reports
* Medical information
* PCP planning documents
* Assistive Communication information such as dictionary of communicative intent, instructions for use, and programming of communication devises.

The sending Case Manager Supervisor will assure that the record is complete prior to transfer.

##

## Confidentiality and Disclosure

Participant’s records, including protected health information, are private and confidential. Records include both electronic and paper documents.

Participant’s medical and administrative information cannot be disclosed to others except as provided by statute. Only the minimum information necessary to conduct business is to be used or shared. Records created by other persons or agencies that are included in a Participant’s record can only be disclosed in accordance with the terms of the release or within the terms of applicable statutes.

When DHHS is appointed as a person’s public guardian or conservator, it has the authority and discretion to authorize disclosure of relevant information in its records, within the scope of its legal appointment. DHHS will make reasonable efforts to maintain the person’s privacy to the maximum extent possible.

Protected information is relevant information that may not be disclosed under the terms of applicable law without appropriate authorization or court order. Such information includes but is not limited to names of reporters who have requested confidentiality; work products between DHHS staff and their attorney; and non-conviction data.

Refer to the Office of the Maine Attorney General’s [Medical Privacy website](http://www.maine.gov/ag/health_issues/medical_privacy.shtml) for links to and a brief explanation of some of the laws most likely to apply to confidential health care information of Maine’s citizens. Refer to the [Privacy and Security of Health Information](http://www.maine.gov/dhhs/privacy/) section of the Department’s website for information about protection of health information and for the contact information for the Department’s Privacy Officer.

A Release of Information is not required in emergency situations or meeting mandatory reporting requirements. Click [here](http://www.maine.gov/dhhs/privacy/DHHS-AZ-11-22.pdf) for Maine Department of Health and Human Services – Authorization for Release of Information form. Community Case Management agencies are required to utilize their own agency release of information forms.

## Conflict Free Case Management

Conflict free case management is designed to ensure that Participants have choice of providers and options are not unduly influenced by providers who both coordinate and offer services. As an example, agencies that provide Case Management Services cannot provide other services to the Participant (i.e. community supports, work supports, etc.).

The concept of conflict free case management also applies to the Person Centered Planning process. The Participant has a choice between and among providers to meet his/her identified service needs. The Case Manager is responsible for ensuring the service options, which include MaineCare and non-MaineCare and paid and natural supports, are known to the Participant.

This choice of providers extends to the provision of Case Management Services. Participants have the choice of either certified community agencies or OADS for Case Management Services.

## Contacts

Title 34-B §5201 6B requires Case Managers maintain at least monthly contact with each Participant in order to ensure that the quality and availability of services and consumer satisfaction are maintained at a high level. The table below summarizes program requirements for minimum contact with Participants:

|  |
| --- |
| **Requirements for Contact with Participants:** |
| **Status** | **Minimum Frequency** | **Face-to-Face (Yes or No)** |
| Home & Community Based waiver | Monthly  | No |
| Public Guardianship | Quarterly | Yes |
| Shared Living Housing  | Every other month | Yes |
| Requirement for all eligible Participants | Visits to Participant’s home twice a year and visits to Participant’s program twice a year | Yes |
| Targeted Case Management (Section 13) |  |  |
| * + Initial Assessment (plan)
 | Within 30 days of initiation of services | Yes |
| * + Re-evaluation of the plan
 | Every 90 days (or as changes in needs occur) | No |
| * + Reassessment of the plan
 | Annually  | Yes |
| Youth on V9 Status | Monthly | Yes |

## Correspondent

Correspondent (or Volunteer Correspondent) is a person appointed by the Developmental Services Oversight and Advisory Board (MDSOAB) to act as next friend of a person with intellectual disabilities or Autism when a private guardian or family member is not available to fill that role. (Correspondent is defined in 34-B M.R.S.A. §5001.1-B). Refer to MDSOAB’s website for more information on the [Correspondent/Volunteer Advocate Program](http://www.mainedsoab.org/About_the_MDSOAB.html).

## Critical Information

In order to ensure the highest quality of service possible, information about the Participant must be readily available and accessible in EIS. Case Managers are responsible for entering Critical Information into EIS and for reviewing and updating this information annually during the PCP process and as changes occur.

## Death of a Participant

The Case Manager’s responsibility when a Participant dies is to ensure that the appropriate notifications are made to the proper individuals and those responsible are making the necessary arrangements. The Case Manager responsibilities are to:

1. Notify the Case Management Supervisor immediately upon the death of a Participant. If after regular business hours, report the death to the Crisis Prevention and Intervention team.
2. Ensure that contact is made with the next of kin or the person responsible for making final arrangements and proceed accordingly.
3. Notification to other individuals in the person’s life is on a case by case basis. The Case Manager should consult his/her Supervisor for direction.
4. Ensure that a Reportable Event form is submitted.
5. Complete the Death Report and Mortality Review Assessment in EIS and appropriate notes as needed.
6. If a SIS interview has been scheduled, notify the scheduler/interviewer to cancel.

If the Participant is a public Ward, refer to OADS website and the [Estate and Financial Management procedure](http://www.maine.gov/dhhs/oads/disability/ds/comm-cm/index.shtml).

## Documentation

Case Managers are responsible for documenting activities with and on behalf of Participants, including but not limited to:

* Intake
* Assessment/Eligibility
* Personal Plan development
* Coordination and Advocacy
* Monitoring
* Evaluation

Refer to MaineCare Benefits Manual [Section 13.07.3: Targeted Case Management Services](http://www.maine.gov/sos/cec/rules/10/ch101.htm) for the requirements of entries to bill for Case Management Services. Refer to [CMS 1500 Billing Instructions Guide](https://mainecare.maine.gov/Billing%20Instructions/Forms/Publication.aspx) and the [MaineCare Benefit Manual](http://www.maine.gov/sos/cec/rules/10/ch101.htm) for information on other MaineCare allowable services.

EIS is the data management information system used to document Case Management Services.

**General Notes**

Notes document and report on the Participant’s progress towards Personal Plan goals. Notes also document significant events in the person’s life. Entries made in EIS must include the dates of Case Management Services and the (electronic) signature of the Case Manager. Notes should be prepared as soon as possible, but no more than 10 business days after the encounter. Each entry should include:

* Date of contact
* Setting where contact occurred such as residence, program, employer, etc.
* If visit was face-to-face, by telephone call, email, a collateral contact, etc.
* Observations, including link to Personal Plan (when possible) and assessment of Participant’s satisfaction with services and other quality of life measures.
* Status of medical, dental and any other health conditions.
* Action, including what happened as a result of the contact with Participant, what needs to happen, and who will do it
* Follow-up, including who, what, where, when and how.

Other situations to include in entries are:

* Significant meetings and follow up activities related to these meetings.
* Ongoing documentation on problematic or unresolved issues and follow-up.
* A plan to address needs that are identified, but lack a resource to get the need met.
* Any major or life-altering events, including changes in family or marital status, housing situation or arrangements, or employment status.
* Significant actions undertaken by the Case Manager or other members of the team related to the Participant's services.

Contact by email should be limited to situations in which a brief exchange of information is shared such as to confirm a meeting. A portion of an email communication can be pasted into a General Note, but it must include introductory and a summary statements. The entire email should not be pasted into EIS as a General Note.

See this [link](http://php.ipsiconnect.org/doc/) for a web-based training on documenting case management activities in EIS.

## Emergency Housing

Emergency housing may be indicated during a crisis or because of a risk to a Participant’s health, safety or welfare. Emergency housing includes the state operated crisis home or through a special arrangement made on a case-by-case with contracted emergency housing providers. A Crisis Team leader authorizes the use of emergency housing.

The Crisis Team from the Participant’s District Office is typically involved and assumes the lead role in affecting emergency housing if the situation can not otherwise be stabilized. The Case Manager will:

1. Ensure that all required Participant specific information is provided in writing prior to admission.
2. Ensure that the Participant, along with his/her necessary personal belongings, go to the authorized emergency housing. This may include transporting the Participant, especially if the move to the emergency house occurs during regular working hours.
3. Schedule an Individual Support Team (IST) meeting within 24 hours to address current needs and future planning.

##

## Emergency Response Rating

The Emergency Response Rating is a system in EIS that identifies Participants who would be contacted first or who would be prioritized with authorities in an emergency evacuation. The Emergency Response Rating is used by the Crisis Team, Case Managers and Supervisors in an emergency evacuation or public emergency such as a hurricane, flood, ice storm, or other public emergency event. The Emergency Response Rating also identifies Participant, family, and provider responsibilities for providing immediate support if needed.

The response rating and information should be reviewed by the Case Manager on a regular basis and updated annually during the PCP process and whenever changes occur.

Alerts which provide first responders with important medical or other information should be included such as if Participant has:

* Barriers to communication
* Visual impairment
* Physical disability and mobility needs
* Mental health issue or diagnosis
* Pets in the home
* Medical equipment (i.e. oxygen)

Refer to the Emergency Response Rating Protocol for the categories and descriptions of the emergency response rating levels.

## Employment

DHHS is committed to supporting career development and meaningful employment for all working age adults, including adults with developmental disabilities or autism. Being employed is part of the natural course of adult life. Employment provides individuals with economic gain, personal growth, and opportunities to contribute to one’s community.

The Case Manager is responsible for reviewing the employment status of Participants, at least annually during the Person Centered Planning process, and documenting that the planning team has reviewed the person’s employment and the ongoing support needs, both natural and paid. If the Participant is not employed then the conversation should be about why work is important, interests, services available and potential barriers to employment. Documentation of the conversations and actions to be taken must be included in the Personal Plan.

When a Participant is earning below minimum wage the Personal Plan should contain confirmation that the Federal and State Department of Labor Certificates have been obtained by the employer. The PCP process should include discussions by the planning team about a plan to move the Participant towards earning the minimum wage or above.

The [OADS website, Employment Services and Supports](http://www.maine.gov/dhhs/oads/disability/ds/employment/index.shtml) has tools and resources to assist in discussions about employment. For more information, go to the [Employment for Me website](http://www.employmentforme.org/), which provides additional resources for workers with disabilities.

##

## Entitlement Programs and Benefits

Case Managers are responsible for assisting Participants in applying for entitlement programs and for the timely completion of benefit applications and reviews (such as MaineCare, Medicare, TANF, Food Stamps, Property Tax Rebate, Heating Fuel Assistance, Low Cost Drug program, VA and SSI etc.).

When OADS acts as Representative Payee or fiduciary, Case Managers will ensure that reports are submitted to Social Security Administration, Veterans Administration, and other entities as needed. Social Security’s Guide for Representative Payees is [here](http://www.ssa.gov/pubs/EN-05-10076.pdf).

Community Case Managers should refer to agency policy regarding private, community case management Representative Payee responsibilities.

## Funding Requests

### Family Support Funds

Each year, a limited amount of funds are available for families caring for a family member (excludes spousal relationships) at home who has a developmental disability. Funds are for families requesting financial support for needed items or services such as respite care, heating oil, car repair etc.. Upon District Office approval, Developmental Services will issue a check directly to the family member requesting Family Support.

The state will not issue a 1099 tax form to the family member for these funds.

Case Managers are responsible for submitting requests to the local Developmental Services office on the form currently in use. Requests should include details regarding how funds will be used. The individual’s Personal Plan should identify the need for the service or item. After approval is received, the Case Manager must submit a completed and signed Family Support Billing form to the District Office.

Supervisors in each office will review requests on a case-by-case basis with attention to the following:

1. Individuals must reside with the family member requesting funds.
2. There is a cap of $1,200 per family for the fiscal year.
3. Requests must be for services or items that cannot be practically accessed through other means.
4. The individual’s plan must identify the need for the item or service.
5. Individuals receiving MaineCare services in their family home through the Section 21 waiver are not eligible for these funds.
6. Requests for camp or vacations will not be approved.

Decisions regarding approval/denial will be communicated to the Case Manager by the District Supervisor or Community Case Management Liaison.

### Professional Services and Wrap Flex Funds

Each fiscal year a limited amount of funds are available to meet the health and safety needs of participants.

 Requests for funding must be made by the participant/ or guardian if appropriate.

The following criteria must be met prior to submitting a request for funding:

1. The need must be identified in the Personal Plan or other supporting documents.
2. The funds must be used to mitigate a clearly identified health or safety concern.
3. Other sources of funding must be explored and efforts to secure other funding documented.
4. The Case Manager must submit the request for funding, along with supporting documentation and original bill to their Supervisor for approval.
5. Funds can be distributed only to approved vendors.
6. Requests from Community Case Managers must be submitted to the Community Case Management Liaison for approval on the [DHHS Case Management Funding Request Form](http://www.maine.gov/dhhs/oads/disability/ds/comm-cm/forms/word/CCM-Funding.doc) , once their Supervisor has approved the funding request.

Funding is approved on a case-by-case basis and is dependent on available funds.

## Home Visit Review Tools

The Shared Living Review Tool and Home Visit Review Tool are under revision.

## Housing Options

There are a number of possible living arrangements for Participants. These range from independent living to ICF-IIDs and Nursing Facilities. The Case Manager is responsible for promoting a Participant’s independence by facilitating and advocating for the least restrictive housing option.

On an ongoing basis, the Case Manager should be discussing the skills needed for the Participant to live more independently and the benefits of moving to less restrictive settings.  The Case Manager is expected to describe all housing options so that the Participant is informed of her/his housing options and choices.  The Participant’s satisfaction with the present living arrangement should be assessed frequently by the Case Manager.

## Individual Support Team (IST)

Participants may, from time to time, experience crisis situations. When a crisis occurs, the support of an Individual Support Team (IST) is often invaluable. An IST consists of members of the Participant’s planning team and other professionals, family, or friends that the planning team determines would be supportive of the person in a time of crisis. The IST is developed by the planning team and operates under the planning team’s direction. The role of the IST is to support the person and provide services designed 1.) to prevent crisis situations, or 2.) provide support during a crisis.

The role of the Case Manager is to coordinate the convening of the Participant’s planning team within seven working days.

Refer to [34-B§ 5206 (4): Crisis and Respite Services](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5206.html) and OADS Policy on Individual Support Teams dated 01/23/2002.

## Ratio Policy

[According to 34B See 34-B 5201-6(D)](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5201.html) an overall ratio of one Case Manager to every 35 Participants in each District must be maintained. The ratio must be calculated separately for staff employed by OADS and by community agencies and this ratio must be maintained for each of these groups.

## Supports Intensity Scale

The Supports Intensity Scale (SIS) is the Department’s assessment tool for determining the support needs of Participants. Prior to the SIS interview, the Case Manager ensures that the Participant, guardian and family are informed about the process and secures a signed Release of Information so that the SIS results can be distributed to the Case Manager. Case Managers ensure at least two respondents participate in the interview. Case Managers are required to attend the interview and to use the SIS interview and results in the PCP process.

See [OADS website under Support Intensity Scale](http://www.maine.gov/dhhs/oads/disability/ds/sis/index.shtml) for more information.

# Section IV: Evaluations, Consultations and Ancillary Services

## Consultation and/or Request for Evaluation

The PCP planning team determines which evaluations and consultations are indicated. The results of evaluations and consultations are documented in EIS. The date of an exam or evaluation, including the most recent annual physical, dental, and eye exams are documented in EIS. Any exception to a Participant receiving an exam or evaluation, including a refusal, must be documented in EIS by the Case Manager.

The Case Manager is responsible for ensuring that the Release of Information form is signed when requesting the service or receiving the report. The Case Manager is also responsible for ensuring that a qualified interpreter, if needed, is scheduled to attend the appointment. Refer to the [MaineCare Benefits Manual Section 1.06-3](http://www.maine.gov/sos/cec/rules/10/144/ch101/c1s001.doc) for information on MaineCare coverage of Interpreter Services.

When requesting an evaluation/consultation:

* Request the referral one to three months prior to the date the report is needed, and make sure evaluator is aware of relevant timelines, i.e., date of Personal Plan review.
* Complete a Referral Form if one is requested by the service provider.
* Attempt to ensure that a person who is knowledgeable about the Participant is available to the therapist or clinician during the evaluation/consult.

## Communication Therapy and Services

Participants have diverse communication modes, which require appropriate assessment and remediation of communication barriers to maximize independence and self-determination. Communication therapy can accomplish a variety of goals. Case Managers should know what the outcome of therapy is in order to access the appropriate service. Case Managers are responsible for monitoring the Participant’s access and receipt of communication therapy and services.

Case Managers should consult with the DHHS Consultant on Deafness or agencies such as AlphaOne or the Aging and Disability Center (ADRC) within their local Area Agency on Aging for more information and resources.

Communication therapy includes the following services:

### Augmentative & Alternative Communication (AAC)

Individuals who do not communicate effectively through spoken language may benefit from high-technology single purpose devices or from mid-technology “off the shelf” assistive communication tools, such as tablets with applications (programs) that provide picture-based or text-based forms of communication paired with the device’s speech generation ability.

If the Participant requires a high-technology single purpose device, Case Managers should refer to a Speech Language Pathologist (SLP) with expertise in AAC evaluations (covered by Section 109) who will assist them in completing the prior authorization request required for purchase of single purpose AAC devices under Section 60: Durable Medical Equipment. Programming of AAC devices and client-centered therapy to client and staff to ensure proper use of the device is covered under Section 109.

### Communication Assistive Technology (AT) Services

Section 109 will not cover the cost of “off the shelf” tablet technology, apps, or other devices that have multiple purposes and which permit internet access. The purchase of these forms of Communication Assistive Technology is covered under the Section 21 waiver as “communicators” and can be purchased by a Durable Medical Equipment provider (providing certain requirements are met). Training to staff regarding customization of the program remains a gray area with the Department offering some resources through its contracts. Section 109 has a provision for providing such training if properly justified and prior authorization is obtained. Section 21 can also be used to provide such training.

### Audiological Services

Audiologists identify hearing problems and assist in remedying these problems, including recommending amplification devices such as hearing aids. The American Speech, Language and Hearing Association recommends all adults be screened for hearing loss at least once every decade through age 50 and at 3-year intervals thereafter. If younger adults have risk factors, including existing hearing loss or conditions such as Downs syndrome associated with early age-related hearing loss or frequent ear infections, he/she should be screened more often.

Refer to Section 109 of the MaineCare Benefits Manual for covered hearing tests and services.

Hearing aids for adults are not covered by Section 35: Hearing Aids and Services. Hearing aids can be covered under Section 21 or the specific programs listed below:

* Vocational Rehabilitation (VR) can provide hearing aids if the individual is a VR client or the hearing aids impact the individual’s ability to maintain current employment.
* Maine Center on Deafness can provide one hearing aid for adults over 65 who meet income eligibility requirements through the Telecommunication Equipment Project. The goal of this project is to increase older adults’ independence and safety by providing them access to a telephone and/or other methods of communication.

### Non-traditional Communication

Individuals who are deaf, hard-of-hearing, or hearing and nonverbal who use signs or gestures as a major communication mode may benefit from specialized services directed toward assessment and sign-based or visual gestural-based therapy to improve client ability to independently communicate in all environments. Staff may benefit from consultation to improve their signing and visual gestural skills in order to communicate effectively and directly with the client. Traditional Speech Language Pathologist training does not include methods to assess and/or provide therapeutic services for persons who sign or gesture. The Department refers to these modes as well as mixed modes including a combination of limited verbal skills, gestural skills and/or picture-based communication skills as Non-traditional Communication.

Section 21 covers assessment and habilitation of signing and gestural skill in its Non-traditional Communication Services. For individuals served by other MaineCare services, such as Section 29, the Department has contracts to provide assessment and limited therapeutic services.

### Interpreter Services

Interpreters are professionals who are specifically trained to take information from one language or communication form and change the message to another language or communication form in order to allow full communication between two individuals that do not share a common language. While not a communication therapy, interpreter services are required in situations where individuals who have Limited English Proficiency (communicate through a different spoken language or through sign language or gesture) are expected to be informed or make decisions about their care, participate in medical appointments, or be involved in legal proceedings.

It is expected that Case Managers will communicate directly with the Participants that they serve, however, if there is a language barrier to direct communication Case Managers should utilize interpreter services. Sign language interpreters for sign language users and visual gestural communication users must be licensed in Maine. If the individual uses a non-standard form of signing, such as limited signing or visual gestural communication, a specialty interpreter, called a Deaf or Relay Interpreter may need to be used. Depending on the individual, interpretation may be provided in person or via telecommunications. All interpreter services are confidential services.

State Case Managers should know and follow the Department’s [Language Access Policy](http://www.maine.gov/dhhs/policies/dhhslanguageaccess.pdf). Community Case Managers should know and follow their agencies’ contractual obligations as well as their agency’s policies on communication access.

[MaineCare Chapter 1.06-3: Interpreter Services](http://www.maine.gov/sos/cec/rules/10/144/ch101/c1s001.doc) provides for the reimbursement of interpreter costs for appointments specifically for medical or healthcare.  Interpreter services are reimbursed by DHHS for Person Centered Planning related meetings and Personal Plan development. Refer to OADS’s website for the [OADS Process for use of Interpreters in the Person Centered Planning Process](http://www.maine.gov/dhhs/oads/disability/ds/pcp-action-plan/forms.html).

Maine interpreters work primarily through referral agencies. A list of referral agencies for spoken language interpretation is available at the Language Access Policy link above. An expanded list of sign language interpreters is available [here](http://www.maine.gov/rehab/dod/resource_guide/).

## Dental Services

Some procedures for pain and medically necessary dental procedures may be covered by MaineCare through the prior approval processes. See MaineCare Benefits Manual, Chapter II, Section 25: Dental Services. There is limited funding through District Offices to pay for dental services provided through local community providers. These funds are acquired through the planning process and requested from the district supervisor. (See Professional Services/Wrap Flex Funds Section of this manual. Case Managers are encouraged to pursue dental services within the Participant’s community. See [Maine CDC Oral Health Program Guide](http://www.maine.gov/dhhs/mecdc/population-health/odh/maps.shtml) for information and listing of dental clinics.

Dental services may be provided at dental clinics and by contracted sites located at Dorothea Dix and Riverview Psychiatric Centers through contracts arranged by DHHS. Anesthesiology services are available at certain dental clinics upon request.

The Case Manager will provide information on accessing dental providers to Participants, families, and guardians. Participant’s receiving waiver services are required to have an annual dental exam.

Rules governing MaineCare reimbursement for dental services are located in the MaineCare Benefits Manual at [Chapter II, Section 25: Dental Services](http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s025.doc).

## Medical Services

The Case Manager is responsible for monitoring the Participant's access and receipt of medical services. The Case Manager may need to assist the family in locating a physician when requested to do so by a family member. The family/residential provider is obligated to ensure that the Participant receives preventive and needed medical services. The Case Manager assists as necessary to ensure that indicated medical care is provided.

The Case Manager needs to know the name of the Participant’s Primary Care Provider. The Case Manager should also be aware of the presence and status of acute and/or chronic medical conditions. All this information should be documented in EIS.

Certain medical services and supplies can only be reimbursed with prior authorization. Rules governing MaineCare reimbursement for physician services are located in the MaineCare Benefits Manual at [Chapter II, Section 90: Physician Services and Section 60: Medical Supplies and Durable Medical Equipment](http://www.maine.gov/sos/cec/rules/10/ch101.htm). If payment for physician or medical services evaluation or consultation have been explored and reimbursement options are not identified contact your Supervisor for other payment options.

## Nutritional Services

A nutritionist or registered dietitian assists in determining the nutritional needs of an individual and any possible relationship to etiology or current conditions, as well as to plan and implement dietary changes. The role of the Case Manager is to monitor nutritional and dietary recommendations.

**Occupational Therapy Services**

Occupational therapists (OT) provide evaluation and treatment to enhance functional independence. Occupational therapy concentrates on motor skills, perceptual skill, and functional adaptations. Occupational therapy services require a physician’s order. Services must be medically necessary. The role of the Case Manager is to work with the planning team to identify and monitor the Participant’s need for occupational therapy and to ensure recommendations are followed. Refer to the [MaineCare Benefits Manual, Chapter II, Section 68: Occupational Therapy Services](http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s068.docx)for more information on Occupational Therapy Services.

**Physical Therapy Services**

Physical therapists (PT) evaluate and treat poor postural reflexes, disorders of tone, movement, strength, balance, or coordination. Physical therapy may be appropriate for Participants who have problems with posture and locomotion.

Physical therapy services require a physician’s order. Services must be medically necessary. The role of the Case Manager is to work with the planning team to identify and monitor the Participant’s need for physical therapy and ensure recommendations are followed.

Refer to the [MaineCare Benefits Manual, Chapter II: Section 85 Physical Therapy Services](http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s085.docx) for more information on Physical Therapy Services.

**Psychologist Services**

Psychologist/Behavioral Consultant services require a physician’s order to be reimbursed by MaineCare. Refer to theMaineCare Benefits Manual [Chapter 65: Behavioral Health Services](http://www.maine.gov/sos/cec/rules/10/ch101.htm)  for more information on Psychological Services. Consult with your Supervisor about additional resources. Referrals to psychologists/behavioral consultants include:

* Recommendations for a behavior modification program.
* Evaluation of Participant suitability for psychotherapy.
* Severely Intrusive Plans which have additional requirements for evaluation and monitoring.

## Psychotropic Medication Reviews

The Case Manager is responsible for monitoring that psychotropic medication reviews are done at least twice per year and that appropriate laboratory testing has accompanied these reviews. The Case Manager should advocate for medical evaluation of a Participant using psychotropic medications both before and during treatment. The Case Manager should advocate for additional medication reviews, if he/she or other members of the planning team have continuing concerns about a Participant’s behavioral or emotional issues.

Reviews and changes in the medication regime of a Participant should be documented in EIS, including in General Notes, 90-day reviews, PCP, V6 (V7) Assessment, and Critical Information sections.

[Refer to 34-B Section §5605 8(D)](http://www.mainelegislature.org/legis/statutes/34-B/title34-Bsec5605.html): Rights and basic protections of a person with an Intellectual Disability or Autism.

**Speech Language Pathology Services**

Speech Language Pathologists (SLPs) assess and offer therapeutic services to improve spoken communication and some are specifically trained in the evaluation of high-technology devices to assist and augment spoken communication (AAC devices). Assessment focuses on verifying the existence of communication delay or disorder through standardized testing, describing spoken language abilities and providing recommendation for programs of remediation (speech therapy).

Speech assessment and therapy are covered services under MaineCare Section 109: Speech and Hearing Services. In order to be authorized, speech therapy must be related to a negative change in the person’s ability to speak and the assessment must include a statement of rehabilitation potential. Maintenance therapy is not covered by Section 109, but is covered by the Section 21 waiver.

Consultative services to staff within a coaching model is often very effective at increasing client communication skills and can be covered by the Section 21 waiver or under the Non-traditional Communication contract.

Refer to the [MaineCare Benefits Manual, Chapter II: Section 109: Speech and Hearing Services](http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s109.doc) for more information.

**Vision Services**

Vision services are a MaineCare benefit that pays for an annual routine eye exam if the person resides in an ICF-IID. All other adults are covered for one routine eye exam every three years unless there is a specific medical condition or medication use that impacts vision. MaineCare will pay for one pair of glasses per lifetime when the power of the lenses is 10 diopters or higher. Medicare does not pay for routine eye exams or eye glasses, only for medical conditions that impact vision.

The Case Manager is responsible monitoring the Participant’s access and receipt of vision services. If the individual also has hearing loss, even small changes in vision may impact the person’s ability to understand speech and can be misunderstood as a cognitive decline.

Rules governing MaineCare reimbursement for vision services are located in the MaineCare Benefits Manual at [Chapter II, Section 75: Vision Services](http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s075.doc).

**Section V: MaineCare Services**

MaineCare funded services available to Participants eligible for developmental services include Home and Community Based Service (HCBS) waivers. Refer to the [OADS website under MaineCare](http://www.maine.gov/dhhs/oads/disability/ds/MaineCare/index.shtml) for services for adults with developmental disabilities including waiver programs. MaineCare members may receive covered services as detailed in the MaineCare Benefits Manual, but can receive services under only one Home and Community Based Service waiver at a time.

Refer to [MaineCare Benefits Manual Updates](http://www.maine.gov/dhhs/oms/rules/index.shtml) for proposed and recently adopted changes to the rules that implement MaineCare policies.

**Home and Community Based Waiver Services**

OADS partners with the Office of MaineCare Services which performs rulemaking to implement or update MaineCare policies regarding covered services and related reimbursement. HCBS waivers offer MaineCare beneficiaries the ability to live in a community based setting as an alternative to receiving medically necessary care in an institution.

An individual must be determined to be financially eligible for MaineCare and meet the medical eligibility criteria for care in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) to receive services Home and Community Based Waiver Services under Section 21 and Section 29.

**Section 21: Home and Community Based Waiver (Comprehensive Waiver)**

Section 21, named the Comprehensive Waiver, provides for home supports, community supports, work supports, employment services, and other services to eligible adults age 18 and older. Participants receiving Section 21 are not eligible to receive services and supports under another Home and Community Based waiver (such as Section 29). Services provided under the Comprehensive Waiver cannot duplicate other MaineCare services supplement, rather than replace informal natural, non-paid supports. Services are recommended and documented by the planning team through the Person Centered Planning process.

Refer to [Section 21 of the MaineCare Benefits Manual](http://www.maine.gov/sos/cec/rules/10/ch101.htm) for the description of covered services under the Comprehensive Waiver.

**Section 29: Home and Community Based Waiver (Support Waiver)**

Section 29, named the Support Waiver, provides for community supports, work supports, employment services, and other services to eligible adults age 18 and older who live on their own or with a family member. The Participant must have an adult service Case Manager or have begun the transition to an adult services Case Manager. Participants receiving Section 29 are not eligible to receive services and supports under another Home and Community Based Care waiver (such as 21). Services provided under Section 29 supplement, rather than replace, informal natural, non-paid supports. Services are recommended for Participants through the Person Centered Planning process.

Refer to [Section 29 of the MaineCare Benefits Manual](http://www.maine.gov/sos/cec/rules/10/ch101.htm) for a description of covered services under the Support Waiver.

## Waiver Application

An application for Section 21 and Section 29 waiver services requires a signed Department approved Choice letter, a complete and current medical assessment (the BMS-99 or approved assessment form), and a service plan developed in the last six months that identifies needed waiver services. Waiver application packets are submitted to the Resource Coordinator in the local District office.

Refer to the MaineCare Waiver Programs section of the OADS website under Waiver Forms for the forms that must be completed for an [Initial Waiver Classification](http://www.maine.gov/dhhs/oads/disability/ds/MaineCare/initial-applications/index.shtml).

##

## Initial Waiver Classification

Classification occurs so that waiver services can be authorized. A Participant must be classified for a waiver service and the service authorized before a provider can request reimbursement.

The Waiver Manager notifies the Participant or guardian when a funded opening is available by sending the Waiver Notification letter, which is copied to the Case Manager. The Case Manager will then connect with the Participant to discuss service needs and that services are to begin within 60 days of the notice. If the Participant does not respond to the letter, the Participant is removed from the wait list. The Participant may re-apply for waiver services at any time.

The Case Manager is responsible for completing the Initial Classification Packet in EIS. The process is as follows:

1. The Case Manager contacts the Participant to discuss needs and services.
2. If services are needed, the Case Manager and the team will develop a planning document, including descriptions of the waiver services needed by the Participant. This document must update the Participant’s needs and unmet needs.
3. The Case Manager signs and dates the Choice Letter and ensures that it is also signed and dated by the Participant/or guardian. The signed and dated letter indicates the decision to receive Home and Community Based Services (waiver) instead of care in an institution (ICF-IDD) and that the Participant/or guardian is in agreement with the most current Personal Plan. The plan date on the Choice Letter must be the Effective Plan Date. The plan must be less than six months old.
4. The Case Manager must complete the appropriate medical eligibility form (BMS-99) in EIS. This is the DS Comprehensive HCB Waiver Assessment for Section 21 or the DS Support HCB Waiver Assessment for Section 29. The plan date on the BMS-99 must be the date on which the waiver services were discussed with the Participant. The status must describe current skills and there must be details in each of the comment sections. In addition to the hard copy of the Choice Letter the Case Manager must complete the electronic Choice Letter in the BMS-99.
5. The Case Manager sends the Assessment (as described in #4 above) to the District Resource Coordinator. The Assessment is reviewed and locked by the Resource Coordinator (who is referred to in BMS-99 as the Waiver Manager). The Resource Coordinator notifies the Participant/or guardian and the Case Manager when the Participant is classified for waiver services.
6. The Case Manager can add new information to the Assessment by reversioning the locked Assessment.
7. The Case Manager should end date any open wait list justifications for Participants awarded Section 21.

When Participants are currently receiving any other waiver service(s) and the Participant accepts Section 21 or Section 29, the Case Manager must coordinate with Participant’s service providers around this change and how services may differ. The Case Manager and the service providers are responsible for establishing a start date for the new waiver services and coordinating the transition. The packet for initial classification must identify a start date for Section 21 or 29 services. The start date must be planned to be effective after the initial classification process is complete.

**Vendor Call**

When there is a funded opening available (or if the Participant wishes to change services or access a different provider) the Case Manager coordinates a Vendor Call.

1. The Case Manager sends an email to the Resource Coordinator with a description of the Participant’s service needs, but with Participant’s information de-identified. The Resource Coordinator uses the service need information to issue an electronic Vendor Call to all willing and qualified providers.
2. The Case Manager is contacted by providers who are interested in providing the identified supports or services.
3. The Case Manager must document in EIS that the Participant was given a choice of providers.

The Vendor Call meets the federal requirement §(1902(a)(23) of the Social Security Act and 42 CFR §431.51, which requires “that all Medicaid beneficiaries must be allowed to obtain services from any willing and qualified provider of a service.”

Refer to MaineCare Waiver Programs section of the OADS website under Waiver Protocols for information on the [Vendor Call Protocol](http://www.maine.gov/dhhs/oads/disability/ds/MaineCare/protocol/documents/vendor-call.doc).

**Waiver Reclassification**

Waiver services will not be reimbursed beyond the Waiver Reclassification date. An Addendum can never be used to extend a Personal Plan beyond the Waiver Reclassification date.

The Planning team meets 3 – 6 months prior to the Waiver Reclassification date to begin service planning with the Participant.

The Case Manager must submit the following materials to the District Resource Coordinator:

* Annual Personal Plan document
* Updated DS Comprehensive HCB Waiver Assessment for Section 21 or the DS Support HCB Waiver Assessment for Section 29 (BMS-99).

The documentation for continued waiver funding must be completed in EIS between 30 and 60 days prior to the Waiver Reclassification date.

If Participants are no longer choosing or receiving waiver services the Community Case Manager must notify the Community Case Management Liaison within five days if Participant moves out-of-state, or immediately upon the death of the Participant, so that funding can be discontinued. The Community Case Management Liaison will then notify the Resource Coordinator about the change.

**Service Authorization**

The Case Manager is responsible for ensuring that all needs of the Participant and services recommended by the planning team are identified in the Personal Plan (Plan of Care, Service Plan, Individual Support Plan, or Individualized Education Plan).

The Resource Coordinator approves service requests and authorizes waiver services. APS Healthcare is also working with Department to prior authorize select home support services. Additional MaineCare services are anticipated to be subject to the APS Healthcare preauthorization process in 2014.

**Wait List**

Individuals who have been determined eligible for Section 21 or Section 29 services, but for whom there is not an available funded opening, are placed on a wait list. The Wait List Notification letter, which indicates wait list status, is sent to the Participant/or guardian and the Case Manager. Individuals on a wait list are assigned to available openings in accordance to policy. Funded openings for the Section 21 wait list are assigned a priority level determined by level of need according to priorities described in rule. Funded openings on Section 29 are issued chronologically based on the date of the approved application.

**Other MaineCare Services**

**Section 13, Targeted Case Management**: Section 13-03-4(A) refers to Case Management Services for Adults with Developmental Disabilities.

[Refer to MaineCare Benefits Manual, Section 13: Targeted Case Management](http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s013.docx).

**Section 113: Non-Emergency Transportation (NET) Services Waiver or Transportation Services**

Non-emergency Transportation (NET) Services provide rides to MaineCare covered services for eligible MaineCare members when no other means of transportation is available. The State has contracted with organizations, referred to as Brokers, to arrange rides for eligible MaineCare members. NET services are provided under a waiver through CMS.

Members must meet the eligibility criteria of [Section 113: NET services](http://www.maine.gov/sos/cec/rules/10/ch101.htm) to receive services. Participants must demonstrate that there is no other means to reach the covered service before being eligible to receive transportation services contracted through DHHS.

# Appendices

## Appendix A: Case File Record Retention

|  |  |  |
| --- | --- | --- |
| Contents | Active File | Historical File |
| Planning Documents |
| Person Centered PlanIndividual Support PlanIndividual Education PlanCrisis Support PlanBehavioral Support PlanPlan Reviews (semi, quarterly) | Current year, plus 1 | 4 years |
| Professional Evaluation Reports |
| PsychologistCounselingOccupational TherapyPhysical TherapySpeech/Language/CommunicationVocational Rehabilitation | 5 years or most current | Retain permanently |
| Medical Reports |
|  | Current year, plus 2 years | Retain permanently |
| Home and Community Based Waiver |
| BMS 99  | Current year, plus 1 year | 4 years |
| Waiver Related CorrespondenceAcceptance LetterPriority Level LetterGuardian Decision Letter (Choice Letter) | Retain permanently |  |
| Disability Rights Center and Legal Documents |
| Information Release Authorization | Current Only | None |
| Guardianship Appointment OrderGrievance and Appeal Documents | Retain Permanently |  |
| Paper Correspondence | Current and 1 year past | 4 years |
| Financial Information |
| Mortuary Trust Agreement | Retain Permanently |  |
| Miscellaneous Financial Documents |  |  |
| Social Security Determination LetterFood Stamp Review | Current, plus 1 year  | 4 years |
| Eligibility Determination LetterPermission for ServicesIntake Documents | 5 years | Retain permanently |
| Revised 08/21/13 |  |  |

## Appendix B: Links to Agencies and Organizations

Maine Developmental Disabilities Council (DDC) <http://www.maineddc.org/>

Maine Disability Rights Center (DRC) <http://www.drcme.org/>

Speaking Up for Us (SUFU) <http://www.sufumaine.org/>

Center for Community Inclusion and Disability Studies (CCIDS) <http://ccids.umaine.edu/>

1. Revisions are being made to 14-197 Chapter 12: Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Intellectual Disabilities or Autism. The new policy is expected in early 2014. [↑](#footnote-ref-1)