

## Questions and Answers about SCL2

Questions will be updated weekly in a **RED** font.  
 If you have additional questions, please submit them to:  
[SCLQA@ky.gov](mailto:SCLQA@ky.gov)

PLAN OF CARE RELATED QUESTIONS	
QUESTION	RESPONSE
How would I find SCL2 forms and additional information?	<p>The DDID Website is: <a href="http://dbhdid.ky.gov/ddid/scl2.aspx">http://dbhdid.ky.gov/ddid/scl2.aspx</a></p> <p>Remember to always go to the website for the most updated form every time you need one. These forms are the only ones that will be accepted for Level of Care (LOC) and Prior Authorization (PA).</p> <p>Please do not create your own forms. If you are utilizing a business application that creates forms, they must retain their original format.</p> <p>Please refer to the CDS Module: Case Management Documentation                      Found at: <a href="http://www.collegeofdirectsupport.com/ky">http://www.collegeofdirectsupport.com/ky</a></p> <p>This link contains several recorded modules that provide information from Big Day Trainings.</p>
<p>Are the SCL2 forms (LOC Recerts &amp; initials, Life Story, Map 530, Map 531, and Narrative) going to be iPad friendly?                      Our agency is having issues of not being able to open them on iPads. Is there certain software that will open these forms?</p>	<p>Currently these forms are not available for any Tablet use. If you are having trouble using these forms on laptop computers please make sure you have the most recent update to Adobe.</p>
<p>Please explain and define the ‘Periodic’ frequency. If ‘Periodic’ is chosen, does this mean that the units can be used whenever the clinician deems appropriate?</p>	<p>Periodic is the equivalent of “one time only”.</p> <p>Services may be requested with the below frequency intervals:</p> <ul style="list-style-type: none"> <li>• One time only – This should be used for services such as evaluations or the Positive Behavior Support Plan (PBSP)</li> <li>• Weekly - The number of units you are able to bill will be limited to the number of units</li> </ul>

	<p>authorized during the week – Sunday to Saturday</p> <ul style="list-style-type: none"> <li>• Monthly – The number of units you are able to bill will be limited to the number of units authorized during the month, different amounts can be billed from week to week as long as the total monthly authorized amount is not exceeded.</li> </ul> <p>Periodic is not a frequency that is available through SCL2. With SCL2, all requests for services would need to be documented in the weekly or monthly format unless it was for a one time only service.</p> <p>The person’s team should create a plan that will work for the participant. The units could be requested monthly, which would allow for some flexibility of the use of the units within the month.</p>
<p>How do you request respite on an as needed basis? The individual does not use respite every week or every month, just when needed due to an emergency or when the parents go on vacation. This was submitted to Carewise as periodic and I was told it has to be monthly or weekly.</p> <p>If respite is no longer allocated annually, if a provider agency exceeds their weekly or monthly allocation as outlined on the POC are we to assume that won't be billable?</p>	<p>Respite must be requested with a weekly or monthly frequency. There is no longer an option to request respite without a timeframe defined. Respite should be requested with the max amount of monthly units in mind.</p> <p>If a situation arises and more units will be needed, a modification can be submitted.</p> <p>If the provider exceeds the approved amount on a weekly or monthly basis, it will be necessary to submit a modification to the Plan of Care. These can be back dated 14 days from the receipt of the modification by Carewise Health. If a modification is not submitted then the units over the amount approved would not be billable.</p>
<p>When will the SCL2 forms allow CM's to type <b>more</b> information into the Map 530, LOC, Life Story, POC Narrative (on the communication section and where we are to add the CPP and BSP)? As of right now there is limited space.</p>	<p>The life story form has been revised to allow for unlimited narrative.</p> <p>The PBSP and crisis prevention information is included in the section of the plan of care narrative titled: <b>“What others need to know or do to support me and help me to stay healthy and safe”</b>.</p> <p>The Life Story, which is updated at least annually, should contain pertinent historical information about the person as well as current information noting events, activities, overall health and well-</p>

<p>Life story is just a small part of their life. Would a Psycho-social work best here since it really is their life story?</p>	<p>being. The form to use is located on the DDID website: <a href="http://dbhdid.ky.gov/ddid/scl2.aspx">http://dbhdid.ky.gov/ddid/scl2.aspx</a></p>
<p>On the SCL2 Level of Care Recertification Form and Plan of Care Demographic and Billing Information, the Axis diagnoses sections will not print beyond one line, therefore not all information will be submitted. How do we get the rest of the information (for example--Axis III diagnoses) to print so that we can submit all information?</p>	<p>Please include the diagnosis codes only. There is not enough space for diagnoses' descriptions. Carewise Health will send an LOI if just the diagnosis description is documented.</p>
<p>On the Freedom of Choice and Case Management Conflict Exemption form, it states on the bottom "by electronically signing and dating this document, the case manager verifies that the participant/guardian agrees with the information contained on both pages of this form and has electronically signed this document or if not, has signed a paper copy which is kept with the participant's service records." My questions are, #1--there are not 2 pages of this form.....and #2--does the service record NEED a signed copy along with the electronically signed document? I had another case manager bring to my attention that someone at DDID stated a hand-signed copy will be in each chart. If that is the case, the MAP 531 does not indicate this. It only indicates a signed copy will be in the service record IF AN ELECTRONICALLY SIGNED DOCUMENT IS NOT. Please clarify</p>	<p>The form is only one page. Carewise Health requires a signed copy be submitted this may be an electronic signature.</p> <p>907 KAR 12:010, Section 8, allows for the use of electronic signatures. The creation, transmission, storage, or other use of electronic signatures and documents shall comply with:</p> <ul style="list-style-type: none"> <li><b>(a)</b> The requirements established in KRS 369.101 to 369.120; and</li> <li><b>(b)</b> All applicable state and federal statutes and regulations.</li> </ul> <p>Agencies should consult with their legal advisors to determine if their Electronic Signatures policy adheres to other applicable state and federal statutes and regulations beyond the identified KRS.</p> <p>The SCL regulation may be found here: <a href="http://www.lrc.ky.gov/kar/907/012/010.htm">http://www.lrc.ky.gov/kar/907/012/010.htm</a></p>

<p>What is the time frame to get a response on MAP 531 exemption forms? I have been getting my approval/ denial letter after the plan has been submitted to Carewise and then I have to respond to a LOI asking for the approval/ denial letter.</p>	<p>The MAP 531 for an exemption should be sent to DDID prior to submitting information to Carewise Health. They cannot process the request without the approval letter. The turnaround time for receiving a response from DDID is 7 business days.</p>
<p>A provider is under the impression that participants coming into SCL2 will not be allowed the Group Home option. I do not believe this is true and don't recall this being discussed, but wanted to be sure. This is especially important because a gentleman has just received emergency allocation and he currently resides in a group home.</p>	<p>Residential Level 1Service is provided in either a certified and licensed group home with no more than 8 people living in it, or in a staffed residence with no more than 3 people living in it. Please refer to 907 KAR 12:010, Section 4.</p> <p>You will find the SCL regulation here: <a href="http://www.lrc.ky.gov/kar/907/012/010.htm">http://www.lrc.ky.gov/kar/907/012/010.htm</a></p>
<p>We have a question regarding the code/rate changes for SCL2 plans effective now-from the SCL2 POC's we have seen the codes for services are the same as old codes; so how will this effect agencies trying to submit plans under SCL2? HALEY AND MARY</p> <p>Where can we find the new codes?</p>	<p>Many of the codes are different when changing from SCL 1 to SCL 2. The ones that have the same billing codes have had no change in the rate. These services are: OT, PT, Speech, and Specialized Medical Equipment Services.</p> <p>For CLS services in SCL 1 you will use SCL 1 codes until the person transitions into SCL2. As SCL2 does not include CLS services, the codes for Personal Assistance, Community Access Individual, and Community Access Group will not overlap with CLS.</p> <p>For other services with similar codes there are modifiers attached that differentiates these from SCL1 codes.</p> <p>The most current charts with the SCL2 codes can be found at:  <a href="http://www.collegeofdirectsupport.com/ky">http://www.collegeofdirectsupport.com/ky</a>  These are handouts for the module.</p> <p>Mary's Story and can be accessed by clicking on the paperclip in the lower right of the screen.</p>
<p>What works for me section- some</p>	<p>In the POC narrative section titled "What Works for Me" you should complete it from the</p>

<p>individuals communicate via other means than verbally, so do we leave that blank? (Since the next section is what others think works for me) or do we go by what the person shows through behaviors?</p>	<p>perspective of the person based on their method of communication. Behaviors and other actions may be the way a person communicates.</p>																												
<p>Communication section of the POC is confusing, needs to be changed a little bit.</p> <p>What happen and what I am doing sections seem to be the same and are repeated</p>	<p>Please see the table below for examples of this section as found in the POC narrative:</p> <table border="1" data-bbox="751 513 1915 816"> <thead> <tr> <th colspan="4" data-bbox="751 513 1915 553">Communication</th> </tr> <tr> <th data-bbox="751 553 1024 586">What is happening</th> <th data-bbox="1024 553 1226 586">What I do</th> <th data-bbox="1226 553 1503 586">What I think it means</th> <th data-bbox="1503 553 1915 586">What others should do</th> </tr> </thead> <tbody> <tr> <td data-bbox="751 586 1024 646">I am in my room alone at home</td> <td data-bbox="1024 586 1226 646">I begin to yell and hit my head.</td> <td data-bbox="1226 586 1503 646">I am in pain</td> <td data-bbox="1503 586 1915 646">Discern the source of the pain and take the appropriate action</td> </tr> <tr> <td data-bbox="751 646 1024 706">I am with a group of people</td> <td data-bbox="1024 646 1226 706">I begin to yell and hit my head.</td> <td data-bbox="1226 646 1503 706">It is too loud and confusing</td> <td data-bbox="1503 646 1915 706">Help me find me a quieter area</td> </tr> <tr> <td data-bbox="751 706 1024 738"></td> <td data-bbox="1024 706 1226 738"></td> <td data-bbox="1226 706 1503 738"></td> <td data-bbox="1503 706 1915 738"></td> </tr> <tr> <td data-bbox="751 738 1024 771"></td> <td data-bbox="1024 738 1226 771"></td> <td data-bbox="1226 738 1503 771"></td> <td data-bbox="1503 738 1915 771"></td> </tr> <tr> <td data-bbox="751 771 1024 803"></td> <td data-bbox="1024 771 1226 803"></td> <td data-bbox="1226 771 1503 803"></td> <td data-bbox="1503 771 1915 803"></td> </tr> </tbody> </table>	Communication				What is happening	What I do	What I think it means	What others should do	I am in my room alone at home	I begin to yell and hit my head.	I am in pain	Discern the source of the pain and take the appropriate action	I am with a group of people	I begin to yell and hit my head.	It is too loud and confusing	Help me find me a quieter area												
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<p>Things I am figuring out- many do not know of anything they feel they are figuring out- does the team give their input here?</p>	<p>Yes, the team should assist in all areas of the POC. An example for this section might be that the person and their team would determine the best method of communication when the person and their team have trouble communicating and understanding each other.</p>																												
<p>On the POC Narrative section, who do we put as responsible (Staff person, agency, title?)</p>	<p>The agency that is providing the service should be noted in the “Who is Responsible” column.</p>																												
<p>We feel we need more instruction/information regarding the modifications or making corrections to documents.</p> <p>For Modifications that do not require a team meeting, like durable medical equipment, is it OK for the CM to document they spoke to the guardian or does the guardian have to actually sign off on the signature sheet? The</p>	<p>Please refer to the CDS Module: Case Management Documentation found at: <a href="http://www.collegeofdirectsupport.com/ky">http://www.collegeofdirectsupport.com/ky</a></p> <p>As a person’s needs change, there may be need for a modification to the POC. The case manager should facilitate communication between appropriate members of the person centered team to modify the POC. A full team meeting may not be required.</p> <p>The case manager can speak with the guardian and then type the guardian’s name and note that they spoke on a particular date and the outcome of the discussion. The person’s record should</p>																												

<p>process by which Case Managers submit modifications for services has not been clearly defined or what signature documents are requested. Participant signature have been mentioned as being required however not every participant can make their mark or sign the necessary documents which leads to prolonging the process for changes and service implementation. Could this please be discussed in more detail?</p>	<p>contain a signed copy. This can also be electronically signed.</p> <p>For individual signatures, the case manager can document that the person cannot physically sign but that the modifications were discussed with them and then the case manager would indicate how this occurred with the individual and/or guardian's input.</p>
<p>Are Behavior Support Plans/code 96152 to be updated annually? Some Behavior Support agencies are <b>insisting</b> the BSP be requested annually other providers are saying no.</p>	<p>The PBSP should function similarly to the person centered POC. There should be continuous review and a system for determining effectiveness. The PBSP should be revised and updated as indicated through review and team consensus. Revisions to the PBSP may be covered through Consultative Clinical and Therapeutic Services.</p> <p>The need for a PBSP shall be evaluated and revisions made as needed at any time, and at least annually.</p> <p>If a new PBSP is needed, the team should determine if Consultative, Clinical and Therapeutic Services are needed for a new Functional Assessment, prior to revising the PBSP. The functional assessment must support the PBSP.</p>
<p>Since monitoring positive behavior support plans could only be authorized for 3 months, does that mean Positive Behavior Support Plans are only approved for 3 months.</p> <p>What needs to be sent in for the 3 month recertification for positive behavior supports?</p>	<p>No. Positive Behavior Support Plan Service is used to develop the PBSP. The prior authorization of this service does not indicate PBSP approval. It is only for the development of the PBSP. Monitoring of the PBSP is through Consultative, Clinical and Therapeutic Services.</p> <p>Prior to the end date of the 3 month PA, the case manager will submit a modification to add the units being requested to the POC. These will be approved again for a 3 month period, if the annual limit of Consultative, Clinical, and Therapeutic Services has not been reached.</p>

<p>Paperwork -what paperwork is sent to other providers that makes for a complete POC, etc?</p> <p>Just to clarify, are residential provider agencies required to have all optional POC packet documents (for example, person-centered supported employment plan) on file even if we don't provide that specific service?</p>	<p>The POC includes:  Map 530  Plan of Care Narrative  Team Signature Sheet</p> <p>The following is as applicable:  Person Centered Employment Plan  Long Term Supported Employment Plan  Positive Behavior Support Plan</p> <p>Yes, if any of the “as applicable” plans exist for a person, the POC must contain all.</p>
<p>For durable medical equipment put on the SCL2 forms, are the time frames for things like Ensure, adult briefs, etc. still three months and are three estimates still required?</p> <p>I've requested Specialized Medical Equipment-formerly through Map 95-ing the items. Today, Carewise confirmed that it's reflected correctly on the POC along w/the MD's signature on the order. However, they're asking that DDID send me a letter of some kind stating that DDID (or whomever in Frankfort)-who has been processing the Map 95-no longer pays for this (in this case, briefs &amp; Boost). <u>Who do I need to get a letter from to prove to Carewise that DMS/Division of Comm.</u></p>	<p>Specialized Medical Equipment and Supplies services no longer require the MAP 95. There is no requirement for estimates. The case manager requests these items on the Map 530. Carewise Health does not require a letter from DDID for Specialized Medical Equipment and Supplies. Case managers should refer to the DME Fee Schedule located at: <a href="http://chfs.ky.gov/dms/fee.htm">http://chfs.ky.gov/dms/fee.htm</a> to determine the purchasing route.</p> <p>The Case Manager does not need a letter but just needs to document that the requested supply or equipment is not available through DME or any other State Plan program.</p>

<p><u>Alternatives/DDID/etc. no longer pays for these supplies?</u> This is confusing b/c isn't it all Medicaid anyway? This letter also needs to come w/a letterhead, per Carewise. So, my next question....how long is it going to take to get this letter?</p> <p>Clarification needs to be given on the change in the MAP 95 process and what the requirements/process is for that submission.</p>	
<p>Does there need to be an outcome for CM services, as Carewise has stated needs to occur?</p> <p>Does there need to be an outcome/objectives for case management, respite, and residential services</p> <p>For Case Management, Respite and Residential services- are SIS items necessary to justify these services</p> <p>Case Managers have recently informed residential providers (per information distributed by the QAs) that there is no longer a requirement for outcomes and objectives; however the regulations state that the monthly summary is to be an "analysis of progress toward a participant's outcome or outcomes." How residential providers to ensure there are not recoupment issues if/when a participant does not have outcomes and objectives.</p>	<p>Case management, respite and residential do not require outcomes and objectives on the POC; therefore, there is no need to identify SIS supporting questions. However, should a person identify a particular outcome and objective they wish to achieve in the residential setting, that outcome and objective would be included on the POC.</p> <p>The following service components for residential services should be included in the residential notes as applicable to the services provided for that person. This will address the supports provided to an individual who does not have formal outcomes and objectives for residential services:</p> <ol style="list-style-type: none"> <li>a. Adaptive skill development;</li> <li>b. Assistance with activities of daily living including bathing, dressing, toileting, transferring, or maintaining continence;</li> <li>c. Community inclusion;</li> <li>d. Adult education supports;</li> <li>e. Social and leisure development;</li> <li>f. Protective oversight or supervision;</li> <li>g. Transportation;</li> <li>h. Personal assistance; and</li> <li>i. The provision of medical or health care services that are integral to meeting the participant's daily needs.</li> </ol>

<p>According to the Big Day training PowerPoint it states “for each service requested on the POC, the CM should identify 3-5 SIS requested that justify the need for the service.” So from my interpretation I would understand that to mean, if I requested Residential Level 1 services I would need to justify it. However, the FAQ provided to providers who did not attend to Big Day training number 11 asks if outcomes and objectives are needed for residential. The answer provided states “if the person has identified they wish to improve, attain, or retain particular skills related to living in the community while at their residential setting. Person centered goals and objectives should then be developed. Otherwise, there is no requirement for residential goals and objectives.” From reading this, I feel the information appears to be conflicting unless the person wants to live on their own in the community and wishes to work towards those independent skills. While recently having a SCL2 POC a RES level 1 provider stated since the individual was never going to live on their own, needed great supports (per information on the SIS), then goals and objectives did not need to be discussed. Therefore, I was wondering exactly what is correct. Does the CM need to justify each service? Or is residential services an exception?</p>	<p>SIS items can be identified by the sections and item number such as: A3, D1, etc. It is not necessary to write out the complete question or item.</p> <p>Remember to use the Family Friendly version of the SIS which is titled: My Support Profile.</p>
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<p>In SCL 1 the Map 109 allowed for more autonomy for folks to switch up their days as they saw fit from one week to the next by listing multiple ADT providers on the plan and then requesting up to 160 units per week to be shared by those providers. Now carewise says that for this to happen in SCL 2 the case manager must submit a modification essentially weekly to move the units around. There is absolutely no way a case manager can be expected to submit that much paperwork to accomplish this, please advise</p>	<p>Yes. Carewise Health reviews the requested amount and as long as the combination of all providers together does not exceed the weekly limit of 160, it is being approved.</p> <p>It is suggested that providers ask for monthly units rather than weekly to allow more flexibility during the month. The team of providers that are providing “in combination” services should work together to determine how many units each will be providing. With monthly units, the person could use more or less in a particular week, but not exceed the monthly total. However, there will be times that a modification is needed, but it most likely would not be every week. If it is happening weekly then the team probably needs to take another look at the units requested and make any changes to better reflect what is actually happening.</p> <p>The providers have to abide by the limits listed for each service.</p>
<p>Has there been a change in the regulations and guidelines regarding family home providers and the provision or ‘respite’ services”?</p>	<p>Family Home Provider falls into the Level II Residential Service definition. Respite is not available for people who have residential services.</p>
<p>If an individual is currently receiving respite services under SCL1 and transitions to SCL2 after 6 months of this year when respite will no longer be an option, will they be eligible to receive the yearly maximum amount of respite as was available under SCL 1? Or will it be prorated?</p>	<p>No, SCL1 respite will not be pro-rated when a person transitions into SCL2. When the person transitions into SCL2, the Respite limit of 830 hours per calendar year will begin.</p>

<p>Are AFC/FHPs responsible for arranging coverage for their own time off (i.e., payment and setting it up) once a participant has transitioned into SCL 2 services?</p>	<p>The contractual arrangement between the SCL provider and the AFC or FHP should include time off. Respite services are not substituted for the AFC or FHP's time off. The agency is expected to continue to provide residential supports for a person in SCL while the AFC or FHP provider is off.</p>
<p>Are the personnel who provide residential coverage to participants receiving Residential Level II supports during the primary AFC or FHP's time off to have any specific type of training?</p>	<p>Yes. All training and personnel requirements as set forth in 907 KAR 12:010 must be met. An agency prior authorized to provide Level II Residential Services must be available to do so every day of the year.</p>
<p>Clarify the requirement that CM's respond to crisis situations within 45 minutes if necessary</p>	<p>The CM or designee must be able to respond to a call regarding a crisis event within 15 minutes and be able to respond or send a designee within 45 minutes if necessary.</p> <ul style="list-style-type: none"> <li>▪ This requirement has been incorporated into Case Management Training</li> <li>▪ This requirement will be included on the Quality Indicator Tools</li> <li>▪ See page 26 of 144 of the SCL Waiver document located here: <a href="http://dbhdid.ky.gov/ddid/documents/scl/AmendedSCLWaiver.pdf">http://dbhdid.ky.gov/ddid/documents/scl/AmendedSCLWaiver.pdf</a></li> </ul>
<p>Part of the problem is that the forms as they exist are not conducive to electronic fax. Not sure how to correct this but it is a problem.</p>	<p>Please print the forms and then fax them to CareWise Health.</p>
<p><b>CAREWISE HEALTH – RELATED QUESTIONS</b></p>	
<p>Why is it Carewise has not returned any SCL 2 authorizations? Are there sufficient staff reviewing these documents and how many.</p>	<p>A review of 200 SCL2 cases was conducted. Of these 200, 25 were submitted with complete documentation, met criteria and were approved with the initial submission. The remainder of the submissions was placed in Lack of Information (LOI) status. Since 1/28/13, 39 LOI's have been approved with the submission of additional information. This brings the total approved cases of the sample to 64 of the 200.</p>

	<p>The reasons for LOI were reviewed. The top 5 reasons for LOI are:</p> <ol style="list-style-type: none"> <li>1. Missing forms</li> <li>2. SIS specific questions related to goals incomplete</li> <li>3. ICD-9 missing</li> <li>4. Signatures missing</li> <li>5. Incomplete forms</li> </ol> <p>Haley Hammond <a href="mailto:Haley.Hammond@ky.gov">Haley.Hammond@ky.gov</a> and Mary Mann <a href="mailto:Mary.Mann@ky.gov">Mary.Mann@ky.gov</a> are available for on-site technical assistance. Please contact them for help!</p>
<p>Case Management providers are still not receiving authorization from Carewise for all requested supports, instead we are continuing to receive duplicate PA's for case management services.... this has been a pervasive issue and will lead to increased difficulties in ensuring adequate service provision for waiver recipients</p>	<p>Please provide specific examples. The PAs reviewed for approved services have all been copied to the Case Management agency.</p> <p>Please submit specific questions or member issues to Pam Smith at <a href="mailto:pamela.smith6@hp.com">pamela.smith6@hp.com</a> for resolution.</p>
<p>For both SCL and SCL 2, Case Managers are coming across instances where services are remaining unapproved for a glitch within the Carewise approval system where they are being flagged for review and no one has been able to adequately explain why or when they will be corrected. Specific examples can be provided but this is not an isolated occurrence and has been evident for a number of months.</p>	<p>The root cause of this issue is when providers request a modification for a service but continue to bill the service. Since modifications are back dated 14 days unless a start date is specified, this results in claims continuing to be paid. The system will not allow a service to be end dated to create the new approved service line with increased units. CareWise Health will review each of these on a case by case basis and adjust the dates based on paid claims data.</p> <p>There are two simple ways to prevent this issue:</p> <ol style="list-style-type: none"> <li>1. If a modification is submitted, do not continue to bill the service until the updated PA is received; or</li> <li>2. Specify a start date for the new service or increased units and do not bill until the PA is received for the modification.</li> </ol> <p>Please submit specific questions or member issues to Pam Smith at <a href="mailto:pamela.smith6@hp.com">pamela.smith6@hp.com</a> for</p>

	resolution.
<b>EXCEPTIONAL SUPPORTS RELATED QUESTIONS</b>	
<p>What specific forms do CM's need to submit for Exceptional Supports Requests to DDID for approval?</p>	<p>Please refer to the Exceptional Supports Protocol located at: <a href="http://www.chfs.ky.gov/dms/incorporated.htm#12">http://www.chfs.ky.gov/dms/incorporated.htm#12</a></p> <p>SCL Exceptional Supports Request Fax Form is located at: <a href="http://dbhdid.ky.gov/ddid/scl2.aspx">http://dbhdid.ky.gov/ddid/scl2.aspx</a></p> <p>Supporting Documentation should include:</p> <p>A cover letter stating:</p> <ul style="list-style-type: none"> <li>• The participant is currently in institutional setting and transitioning to the community; or</li> <li>• The participant is at risk of not maintaining their life, friends, home and work in the community; and</li> <li>• The assessed needs of the participant based upon the SIS and/or HRST indicate an intense level of supports is required to promote health, wellness and stability.</li> </ul> <p>Team approved Plan of Care documenting:</p> <ul style="list-style-type: none"> <li>• The enhanced service delivery needed (e.g., specific enhanced training requirements or credentialed employee, time of day enhanced staffing ratio required, number of hours of professional staffing, or oversight required) including any support needs for which enhanced professional treatment and oversight is warranted (to include dietary, psychological, or positive behavior support services).</li> <li>• The frequency of the data review by the team and consideration of criteria for reduction of these; and information about alternative measures attempted.</li> <li>• Cost analysis or projected budget for the supports provided for participant.</li> </ul> <p>Request for additional supports needed in the area of skilled nursing shall include the following additional documentation:</p> <ul style="list-style-type: none"> <li>• Specification of hours of necessary RN direct support required for delivery of identified nursing care not delegable per 201 KAR 20:400.</li> <li>• Plan to obtain and monitor clinical outcome data with criteria for reduction as relevant to medical condition.</li> <li>• Specification of additional direct support staffing requirements in amount and time of day with criteria for reduction of these supports; including completion of the expanded requirements for credentialed DSP in the areas of Health Support if appropriate, and</li> <li>• Assessed exceptional needs documented by the SIS and the HRST with a copy of the physician's</li> </ul>

	<p>orders when applicable.</p> <p>Request for exceptional supports based on the exceptional behavioral health or behavioral supports needs of the participant must also include the following (<b>as applicable</b>):</p> <ul style="list-style-type: none"> <li>• Documentation of completion of the expanded requirements for the direct support professional (DSP) credentialed in the area of positive behavior supports;</li> <li>• Documentation the providers' ability to support people with exceptional behavioral health or behavioral support needs which may include implementation of specialized programs, established arrangements with network of community supports. This documentation pertains to a provider's overall or system wide capacity to provide these types of supports;</li> <li>• A functional assessment and any supports developed based on that assessment to include a Positive Behavioral Support Plan.</li> <li>• Any notes from HRC and BIC for plans reviewed;</li> <li>• The form of communication utilized and, as appropriate, specified communication techniques/use of technology. Include a description of efforts toward functional communication;</li> <li>• Quantitative data in the form of frequency, rate, or duration should be provided for each target behavior identified in the Positive Behavior Support Plan. This data must include the most recent three (3) months period of the continuous data collection for each targeted behavior or behavioral health symptom. Data should be in an objective, numerical, and graphical form;</li> <li>• Documentation which may include clinical notes, to indicate that ongoing behavioral health services are necessary to achieve the desired outcomes specified in the POC; and</li> <li>• Behavioral Health Plan, Crisis Prevention Plan and notes from debriefing sessions the CMHC and ICF/IID Mobile Crisis Services.</li> </ul>
<p>There has been conflicting information about waiver recipients who are at extreme need having to wait until their DOB to access the Enhanced Support Protocol... If a person is in crisis and in need of the ESP funding</p>	<p>People will transition from SCL1 into SCL2 services during their birth months. There are no exceptions. The person centered team should work closely together, and meet as frequently as needed, to develop and revise the POC as needed in order to support the person's needs.</p>

<p>why can't extreme situations be reviewed prior to DOB? It was mentioned on numerous occasions by Department staff this would be an option but it appears this has changed.</p>	
<p><b>TRANSITIONING RELATED QUESTIONS</b></p>	
<p>Clarify the date of submission to Carewise Health for people whose DOB and LOC end date are in the same month.</p>	<p>If the person's level of care (LOC) end date and date of birth (DOB) are in the same month, the SCL2 request will be reviewed without penalty. However, providers are serving at risk without an authorization so it would be best practice in these scenarios to submit prior to the LOC end date. Please note that the LOC dates will flow with the original LOC dates and not adjusted to DOB.</p>
<p>Can you please talk about the process of transitioning folks into SCL 2 that currently receive the SCL enhanced rate from an ICFMR transition (those whose funding expires in 2014 &amp; 2015 respectively)</p> <p>I transitioned several folks through the MFP Waiver in 2012. We were supposed to receive the enhanced rate for these individuals for 2 years. After one year, the MFP folks rolled</p>	<p>If a person has transitioned from an ICF through Money Follows the Person (MFP), they will receive an SCL allocation at the end of the MFP period. At that time they will enter into SCL2 as a new allocation.</p> <p><b>New Allocations- Individuals Entering SCL waiver for the first time.</b></p> <p>Within 60 days from the allocation date the case manager submits via fax to Carewise Health for the initial LOC and 120 day POC prior authorization (PA)</p> <ul style="list-style-type: none"> <li>• Copy of Allocation Letter;</li> <li>• A complete psychological evaluation that includes an IQ test and current adaptive behavior assessment;</li> <li>• Physical examination conducted within the last twelve (12) months;</li> <li>• Map 24C as applicable –if receiving existing waiver services;</li> <li>• SCL Initial Level of Care form;</li> <li>• Life Story less than one year old;</li> <li>• Map 530 pages 1 and 2- No Person Centered Plan required at this time;</li> <li>• Map 531; and</li> <li>• Map 350.</li> </ul> <p>Case manager has 120 days based on the PA dates to submit the full plan to Carewise Health for review and</p>

<p>in to the SCL waiver. With the SCL2 documentation and rated, the enhanced rate has disappeared. Is there an exception to the folks that moved to my agency prior to the implementation of the new waiver</p> <p>Is there still a period of T2033@ enhanced rate after MFP ends?</p> <p>Individuals in MFP transitioned into the Enhanced SCL rate for 1 year and then on day 366 it went to the regular rate. Will this continue with SCL 2 or no longer occur?</p>	<p>continuation of services.</p> <p>Within the 120 days submit to Carewise Health for a PA:</p> <ol style="list-style-type: none"> <li>1. My Life Story*;</li> <li>2. Supports Intensity Scale-My Support Profile;</li> <li>3. Map 530;</li> <li>4. Person Centered Plan of Care Document -(Narrative) and Team Signature;</li> <li>5. Updated Map 350;</li> <li>6. Physical examination conducted within the last twelve (12) months*;</li> <li>7. Map 531; and</li> <li>8. Other Maps, plans, and supportive documentation as applicable-, Map 532, PBSP, Supported Employment Plans, etc.</li> </ol> <p>*It is not necessary to send items already sent in the initial packet unless there has been some type of change or update.</p> <p>Once the individual transitions into SCL2 they will receive the rates for services as defined in the SCL2 regulations. There are no enhanced rates for people transitioning from MFP.</p>
<p>If a client's current LOC ends 2-13-14 but their birthday isn't until 10-18-14, is their LOC extended to 10-18-14 or do we send in SCL1 information? Please</p>	<p>If the person's Birth Month occurs after the LOC end date the LOC period and PA will remain unchanged.</p> <ul style="list-style-type: none"> <li>• Case Manager will submit a recertification packet including: (SCL 1 Forms) <ul style="list-style-type: none"> <li>• Map 351;</li> <li>• Map 350; and</li> <li>• Map 109</li> </ul> </li> </ul>

<p>advice.</p> <p>If LOC date ends 2-28-14 and birthday is 3-6-14 do we have to complete scl 1 for 5 days? or can we submit scl 2 prior to 2-28-2014?</p>	<p>Carewise Health will issue a Confirmation Notice of LOC and PA ending on the individual's' 2014 birthdate. Up to 30 days prior to LOC end date, CM shall submit to Carewise Health:</p> <ol style="list-style-type: none"> <li>1. SCL LOC Recertification Form;</li> <li>2. My Life Story;</li> <li>3. Supports Intensity Scale-My Support Profile;</li> <li>4. Map 530;</li> <li>5. Person Centered Plan of Care Document -(Narrative) and Team Signature Sheet;</li> <li>6. Updated Map 350;</li> <li>7. Physical examination conducted within the last twelve (12) Months;</li> <li>8. Map 531; and</li> <li>9. Other Maps, plans, and supportive documentation as applicable-, Map 532, PBSP, Supported Employment Plans, etc.</li> </ol> <p>Yes, you must submit the SCL1 forms and then submit SCL2 forms on the birthdate.</p>
<p>If a person changes case management agency and they receive a new LOC, how does that fit into the transitioning to SCL2? The person is changing case management 2/1/14, current LOC ends 2/28/14 and the birthdate is not until 11/14?</p>	<p>Participants will not transition into SCL2 until 2014 DOB. Updated MAP 109 and admitting/discharging MAP 24C required for case management transfer. If it is time for reassessment then new case manager can complete the MAP 351.</p>
<p><b>PDS RELATED QUESTIONS</b></p>	
<p>Can a consumer use Skype</p>	<p>A required face-to-face visit by the case manager must be conducted in person. Skype or other programs could be</p>

<p>or a similar face to face communication mode through the internet and this be considered allowable through a direct waiver service, like CLS and attendant care through Michelle P. We have denied this possibility in CDO under three CLS service.</p>	<p>used for non-billable contacts.</p> <p>This question also pertains to the employee/participant contact. It has been considered possible by employees/guardians/parents that using this technology may serve as an aid to participants in meeting their outcomes and objectives. After conversations with BHDID, DMS, and the Office of Legal Services (OLS) in recent years, DAILE has stated that this is not an acceptable means of providing a service to a participant.</p>
<p>Who is responsible for serving as the Financial Management Agency? Please Clarify. Also further clarification is needed we feel on what the Case Mngt responsibility is for PDS, it remains unclear to many how PDS and Case Mngt should be integrated and who has what specific responsibilities... despite recent emails.</p>	<p>The corresponding AAA/CMHC in the area is the Financial Management Agency (FMA). A list of contacts has been sent to case manager supervisors' agencies. If you have not received this, please email <a href="mailto:Evan.Charles@KY.gov">Evan.Charles@KY.gov</a> and you will receive a copy.</p> <ol style="list-style-type: none"> <li>1. Once the case manager is aware that the participant wishes to choose a PDS service, the participant should have an employee set up for the employment process, ideally through recruiting and interviewing, but this could also be done through acquaintances of family members, friends, or neighbors. <u>Please note</u> that immediate family members must qualify through the MAP 532 Exemption process. The case manager may assist in this, through providing ideas about possible advertising or through team discussions about who could be available.</li> <li>2. The case manager then informs the participant/team about employee requirements (drug screen, TB screen, CPR/First Aid, College of Direct Support (CDS), any additional trainings, possible educational requirements, and background check requirements [employer is responsible for payment for processing these requirements]). <u>Please note</u> that the funding for these requirements is the responsibility of the employer; the ability to have these requirements paid for the first five (5) employees by Medicaid is not an option.</li> <li>3. Once an employee is qualified, the employer should direct the employee on what duties to be performed as related to the POC.</li> <li>4. As timesheets are completed, the timesheets are to be reviewed by the employer to ensure accuracy. The case manager then reviews the timesheet to ensure that the plan of care is being followed in terms of outcomes and objectives, unit maximums, and regulation maximums.</li> </ol>

<p>How do we complete the Time Sheets for PDS?</p>	<ol style="list-style-type: none"> <li>1. The employee writes in the hours, dates, and attaches supporting documentation.</li> <li>2. The employee/employer is responsible for the identifying information at the top of the timesheet, but the Case Manager may pre fill this information in order to reduce chances of error.</li> <li>3. Each party responsible for the timesheet shall provide a signature at the bottom; calculations at the bottom are optional.</li> <li>4. The Case Manager reviews the timesheet and ensures it complies with PA limits, and POC guidelines.</li> <li>5. The Case manager submits the original page 1 to the FMA for payment processing, retaining a copy of page 1, and the service documentation, page 2.</li> </ol>		
<p>Is there a difference in PDS respite service and traditional respite services?</p>	<p>PDS respite can look a little different. PDS respite is directed by the person and his/her family. They can choose non-SCL staff to provide this service. However, there are outlined training requirements for PDS staff. You can find more information at <a href="http://dbhddid.ky.gov/ddid/scl-regulations.aspx">http://dbhddid.ky.gov/ddid/scl-regulations.aspx</a></p> <table border="1" data-bbox="535 625 1921 1047"> <tr> <td data-bbox="535 625 829 1047"> <p><b>5(1)(a)</b></p> </td> <td data-bbox="829 625 1921 1047"> <p>Participant Directed Services (PDS). The following services may be participant directed and shall be provided in accordance with specifications and requirements established in Section 4 of this administrative regulation, the Supports for Community Living Policy Manual, and the training requirements specified in paragraph (b) of this subsection:</p> <ol style="list-style-type: none"> <li>1. Community access services;</li> <li>2. Community guide services;</li> <li>3. Day training;</li> <li>4. Personal assistance services;</li> <li>5. Respite;</li> <li>6. Shared living; or</li> <li>7. Supported employment.</li> </ol> </td> </tr> </table>	<p><b>5(1)(a)</b></p>	<p>Participant Directed Services (PDS). The following services may be participant directed and shall be provided in accordance with specifications and requirements established in Section 4 of this administrative regulation, the Supports for Community Living Policy Manual, and the training requirements specified in paragraph (b) of this subsection:</p> <ol style="list-style-type: none"> <li>1. Community access services;</li> <li>2. Community guide services;</li> <li>3. Day training;</li> <li>4. Personal assistance services;</li> <li>5. Respite;</li> <li>6. Shared living; or</li> <li>7. Supported employment.</li> </ol>
<p><b>5(1)(a)</b></p>	<p>Participant Directed Services (PDS). The following services may be participant directed and shall be provided in accordance with specifications and requirements established in Section 4 of this administrative regulation, the Supports for Community Living Policy Manual, and the training requirements specified in paragraph (b) of this subsection:</p> <ol style="list-style-type: none"> <li>1. Community access services;</li> <li>2. Community guide services;</li> <li>3. Day training;</li> <li>4. Personal assistance services;</li> <li>5. Respite;</li> <li>6. Shared living; or</li> <li>7. Supported employment.</li> </ol>		
<p><b>UNITS/LIMITS RELATED QUESTIONS</b></p>			
<p>CMs are very confused about the amount of time that CCT PAs are good for.</p>	<p>Prior Authorization (PA) for up to 90 days may be issued for Consultative Clinical and Therapeutic Services per request.</p>		
<p>If all of the CCT units that have been approved are used prior to the end of the 3 month PA, can the</p>	<p>Yes, this is just a modification. The total amount of units requested, however, may not exceed the 160 unit limit for the LOC year.</p>		

<p>team request additional units before the 3 months are up?</p>	
<p>Is the annual cap on units based upon the units that have been approved, or the units that have been billed? (I.e. if a clinician is approved for 12 monthly units and one month only uses 4 units, can the 8 unit be approved again later in the year, or are they lost?</p>	<p>The cap is monitored through the MMIS via audits on claims. The case manager should note when requesting units that appear to be over the annual cap that previously authorized monthly units were not used.</p>
<p>In regard to billing for Community Access Group: CA pays \$8 per unit and CA Group pays \$4 per unit... In the instance that two participants want to receive their CA together, would the first be billed as CA (\$8) and second as CA Group (\$4)... This is what we assume, but we don't see it clearly stated anywhere in the regulation...</p>	<p>The service for this event would be Community Access Group for both individuals at \$4.00 per unit.</p>
<p>What is the cap on</p>	<p>Community Access will be prior authorized for up to 6 months. Community Access, in combination with Day</p>

<p>allowable units for Community Access? I believe it's only authorized for six months, but I can't find the cap allowances.</p>	<p>Training, Supported Employment (including employment hours), and Personal Assistance cannot exceed 16 hours daily. If Community Access services are needed beyond the PA'd 6 months, the case manager should submit a modification with justification for continuing use. Community Access services are designed to result in an increased ability by the participant to access community resources by natural or unpaid supports. Community Access services shall have an emphasis on the development of personal social networks for the person. A person may have Community Access services for more than one outcome, or have Community Access in and out of their POC as needed to make the community connections. There is no cap as to the number of units a person may need during the POC year. The focus is more on how it is used rather than how much is used.</p>
<p>Is there a limit of outcomes that day training has to have for approval of services?</p>	<p>There is no specified limit of outcomes for day training. However the outcomes should be individualized to the person's needs and interests and reasonable for the amount of units requested.</p>
<p>If approved for 40 one time units for a Functional Assessment could the provider complete the FA as quickly as possible...say over 2 days working on it 5 hours each day (total of 40 units)?</p> <p>If so, when the provider bills it, would we submit the billing for the day the FA was completed?</p> <p>Since there was only one billing date of service (for the 40 units), would we only complete one progress note detailing what was accomplished</p>	<p>The PA will be issued for a 3 month period for a specific number of units. The provider will have the entire 3 month period to utilize all authorized units. So using the example below a PA would be issued for the FA and the provider could complete it in however many days as necessary documenting and billing for the correct amount of units used on each date of service.</p> <p>The provider would bill each date of service independently for the corresponding number of units used that day.</p> <p>A progress note should be done documenting all activities completed on the corresponding date of service. If units are billed on separate dates/each day the behavior specialist works on the FA, we would expect to see a separate staff note for each date, including start and end times and a summary what was done.</p>

during those 40 units?	
DOCUMENTATION RELATED QUESTIONS	
<p>According to the regulation, the Day Training monthly summary must include “An analysis of the efficacy of the service provided including recommendations and identification of additional support needs.”</p> <p>Since most Day Training staff who write monthly summaries have a high school diploma or GED or neither, can you please give specifics on what reviewers will be looking for regarding this requirement.</p>	<p>This is a basic description of how the person has benefited from Day Training Services during the month and identifies any changes or support needs that should occur. The person who works with the participant the most should have valuable input to document and share with the team about whether or not the Day Training piece of the person centered POC is working or not. The Direct Support Professional (DSP) most involved will have the clearest insight about why or why not a particular approach, teaching mechanism, or opportunity is helping a person achieve their outcome. And that same person is in the best position to notice when something needs to be changed, recommend changes, or celebrate accomplishments.</p> <p>907 KAR 12:010, Section 1, (22) Direct support professional... (e) has the ability to 1. Communicate effectively with a participant and the participant’s family; 2. Read, understand, and implement written and oral instructions; 3. Perform required documentation; 4. Participate as a member of the participant’s person centered team if requested by the participant.</p>
<p>We have encountered a lot of problems with getting doctors to write out prescriptions. Almost all have moved to e-scripts (which allows a lower liability on their part by not having their signature floating around) which has caused us a lot of problems of obtaining written out and signed prescriptions. Furthermor</p>	<p>E-Scripts printed out and signed by the doctor is acceptable. Carewise Health will accept a Pharmacy printout of E-Scripts with the Electronic Signature of the Physician.</p> <p>The Board of Pharmacy considers the E-Script as the original and that no other script should be printed. So, DDID staff will not be looking for a handwritten prescription if an E-Script exists. DDID recommends that providers use the pharmacy printout that comes attached to the medications as the prescription.</p> <p>Please contact your agency DDID Nurse if you have further questions.</p>

<p>e, pharmacies have been unwilling to allow us to have copies of the prescriptions as well. How is DDID moving forward with this? We are already VERY limited in the number of doctors that will see our individuals due to their insurance. We have also encountered doctors stating that “this is our problem and that we should consider ourselves lucky that we see them</p>	
<p>Can we get a specific response on this as to what the division expects to see in a record on an annual dental exam? And/or what you all would consider best practice</p>	<p>The SCL Regulation requires that providers maintain a record for each participant served that contains the results of an annual dental exam. With or without teeth, oral health is an important component of a person’s overall well-being.</p> <p>Even if a person is edentulous, they should have their mouth and gums checked by a professional in that field. Not only for gum care and hygiene reasons, but for specific oral health and disease prevention. Dentists are frequently the first to identify mouth cancers. Early diagnosis of mouth and throat cancer is crucial because these cancers caused by HPV and tobacco are so frequently fatal if diagnosed at late stage.</p> <p>The regulation does not specify that the requirement for dental exams only applies to people who have teeth. Also, dentists do recommend that people who are edentulous still have routine exams.</p> <p>If a general practitioner checks their gums during the physical exam, this should be documented by the physician.</p>
<p>Could the Department please clarify what is the Summary Sheet and what elements should be</p>	<ul style="list-style-type: none"> <li>• Participant Summary <ul style="list-style-type: none"> <li>○ The Participant Summary is intended to be a quick reference document that captures the most critical need-to know information from the participant’s plan of care. It should combine the critical elements previously included in Crisis Prevention Plans (ALL health/safety/welfare issues) with</li> </ul> </li> </ul>

<p>present within that document?</p> <p>Please discuss and clarify the expectations for the participant summary.</p> <p>Can DDID clarify if this document will include aspects of what would formerly be known as the</p>	<p>more general information about the individual's preferences and needs.</p> <ul style="list-style-type: none"> <li>▪ The Participant Summary should include all the information a direct support staff person needs to know to provide quality supports for the participant ~ items that are important to and for the person</li> <li>▪ This should be person centered and may include items like: <ul style="list-style-type: none"> <li>• I prefer to take a shower in the morning. I do not like to take a bath.</li> <li>• Don't expect me to talk to you before I've had my morning coffee. I like it to be quiet and peaceful in the morning, so please don't turn on the TV until at least after breakfast.</li> <li>• It is important to me to watch XXXXX on TV every Monday night. If you, as a staff person, really want to watch football, then you should ask to take Mondays off during Football season.</li> <li>• I do not like to eat green vegetables, but will agree to have a small portion if you remind me that the doctor said it is important to eat a balanced diet.</li> <li>• I attend YYYYYYY church every Sunday. It's important to me to arrive early, so I can have coffee and with my friends there. That means we need to leave the house no later than 9:15.</li> </ul> </li> <li>○ Under the Crisis Prevention Plan system, people who don't display disruptive behavior when their preferences are not honored did not consistently have their preferences written down or communicated to staff. The broader Participant Summary is intended to ensure that direct support staff know each person's preferences and interests, which will improve quality of life.</li> <li>○ The agency could choose to call the document "Participant Summary" or may elect to continue using the title "Crisis Prevention Plan" as long as the pertinent information is included <ul style="list-style-type: none"> <li>▪ Each agency should have a policy addressing the participant summary</li> <li>▪ The participant summary must be current and updated as changes occur</li> </ul> </li> </ul> <p>Yes, the Participant Summary Sheet should include the health/safety/welfare items that would previously have been included in a Crisis Prevention Plan. If an agency elects to also incorporate the participant's picture and information they would previously have included in a Face Sheet (date of birth, MAID number, etc.) that is an acceptable practice. The Participant Summary is intended to serve as a quick reference sheet that includes all the</p>
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<p>crisis plan and can it also incorporate other documents currently utilized such as the Face Sheet and Picture requirements? ... and to build on this question.... wouldn't preferred items and communication and some of those items you are describing be on the new narrative form?</p>	<p>information a direct support staff person needs to know to provide quality support for the participant, which includes information about what is important to the person in addition to health/safety/welfare issues.</p> <p>It is true that the new Narrative form also includes information about the individual's preferences. The Participant Summary Sheet should include information that can be found in other documents in the participant's record, including but not limited to: a Positive Behavior Support Plan, Physician's Orders and/or Protocol, Rights Restrictions, the Life Story, clinical assessments such as a Physical Therapy Assessment, and the Narrative. The Participant <b>Summary</b> is intended to be a <b>summary</b> of the critical information each direct support staff person needs to know to be effective in providing supports for that person, collected into one document.</p>
<p><b>SUPPORTS INTENSITY SCALE (SIS) RELATED QUESTIONS</b></p>	
<p><b>If there is a change in the client's behavioral status, can a new SIS Assessment be recommended by the team and completed ASAP?</b></p>	<p>Yes, if there is a significant change in a person's support needs, the case manager would need to make the request to the SIS trainer and DDID staff person Raymond Johnson at <a href="mailto:Raymond.Johnson@ky.gov">Raymond.Johnson@ky.gov</a></p>
<p><b>Are there any time constraints on the SIS (i.e. can only have an assessment every years, etc.)?</b></p>	<p>The SIS is completed once every other year; however, the case manager can request a SIS be completed as referenced above. Send requests to <a href="mailto:Raymond.Johnson@ky.gov">Raymond.Johnson@ky.gov</a></p>
<p><b>If the information or</b></p>	<p>Yes, the case manager would need to make the request to the SIS trainer and send to <a href="mailto:Raymond.Johnson@ky.gov">Raymond.Johnson@ky.gov</a></p>

<p><b>scoring on the SIS appears to be inaccurate, may a new SIS assessment be requested? If so, who can request a new assessment?</b></p>	
<p><b>Can additional training on the SIS be provided to non-Case Management providers</b></p>	<p>Yes, thank you for the suggestion. DDID will develop webinar training for all providers. This training will be available June 2014.</p>
<p><b>Who would make the clinicians aware of the SIS assessment?</b></p>	<p>The Case Manager is notified of the SIS assessment and is responsible for identifying and notifying those that know the individual the best. DDID will complete a SIS assessment in the third month before the person's birthdate (so, in January, DDID is completing SIS assessments for people who have April birthdates). This is done every other year. The DDID SIS assessor contacts the case manager to schedule. The case manager is responsible to invite the family/guardian as applicable, and work with the individual and family/guardian to identify the best respondents. To be a respondent, the only criteria is that you must have known the person for at least three months, have spent significant time with the individual recently, and also be able to answer questions in a group interview format. There must be at least two qualified respondents. However, if there is a large group of attendees, the SIS may take longer which may frustrate some. Research with the assessment has not shown that the results are any more accurate. DDID encourages case managers to look for respondents from different areas of the person's life, if possible, as that helps to get the most complete picture. A clinician could certainly be one of the respondents; as long as they really know the person well enough to be able to answer detailed questions about the person's support needs (what does it take for them to be successful in home living, community living, lifelong learning, etc.).</p>
<p align="center"><b>Human Rights Committee (HRC)/Behavior Intervention Committee (BIC) RELATED QUESTIONS</b></p>	
<p>If a person-centered team determines that one or more current rights restrictions may be reduced or rescinded,</p>	<p>Since rights restrictions originate with the person-centered team, the team may reduce or rescind a rights restriction. Discussion and the team decision should be reflected in the Plan of Care by the case manager as a part of on-going documentation.</p>

<p>does the Human Rights Committee need to review prior to discontinuing the rights restriction?</p>	
<p>What must be included in the plan presented with a proposed rights restriction to reduce or rescind the restriction?</p>	<p>The plan may include research to try another way to achieve the outcome without a rights restriction, training or coaching for the participant/family/friends, consideration of changes to the environment where the person lives or works, education or training about responses for the staff supporting the person, and/or a change or addition of supports. This plan is in addition to a positive behavior support plan if the participant has one which includes a rights restriction. A positive behavior support plan is not necessary to reduce or rescind a rights restriction but a rights restriction may be a part of a positive behavior support plan; all positive behavior support plans must be annually reviewed and approved by the Behavior Intervention Committee, and by the Human Rights Committee if the plan contains restrictive measures or a rights restriction.</p>
<p>Do all positive behavior support plans have to be reviewed by the Human Rights Committee?</p>	<p>No, positive behavior support plans have to be reviewed prior to implementation by the Behavior Intervention Committee upon being updated or changed, and at least annually. HRC review should occur only if the plan includes restrictive measures or a rights restriction.</p>
<p><b>STAFF/PERSONNEL RELATED QUESTIONS</b></p>	
<p>How is it that all of a sudden on a Personnel Checklist it states now that Providers have to do the SAM and LEIE exclusion checks? This is not is regulation so how can something like this occur without even notifying Providers and most Providers still are not even aware of this! If this is a</p>	<p>The newly revised version of the personnel checklist no longer includes the SAM and LEIE requirements. These are required by Medicaid but are separate from the SCL regulations.</p> <p>The Medicaid requirements can be found here <a href="http://chfs.ky.gov/dms/term.htm">http://chfs.ky.gov/dms/term.htm</a> . Questions pertaining to this should be addressed to Medicaid.</p>

<p>new requirement, although not in regulation...when is it effective? If not in regulation, how and when will Providers be held responsible for something that has just appeared in a personnel checklist?</p> <p>Updated personnel checklist forms indicate 2 additional personnel screenings not designated in regulation or the policy manual... namely the SAM and LEIE exclusion checks. Providers have not been informed how to review these nor that were they to be initiated at any time over the previous year...</p> <p>The SAM exclusion check is a check for business entities and does not appear to be a check of potential staff members. What is the purpose of this and why would it need to be done for each new hire</p>	
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<p>How do we prove that we did a SAM check since there is no print-out? Do we just write down that we did a SAM check? That isn't acceptable for any other background check. In addition, SAM file will not open completely unless you have a brand new version of Excel. Is there any other way to open them without buying Microsoft yet again? Medicaid states that LEIE and SAM be checked every month for every employee and provider. Rather onerous. Is there a way to require those checks initially and 25 % yearly like other checks?</p>	
<p>We have had recent questions about whether applicants for employment or employees may be required to bear the cost of pre-employment background checks.</p>	<p>The Kentucky Labor Cabinet is quite adamant that this is not permitted. The Labor Cabinet has consistently interpreted KRS 336.220 to prohibit an employer/potential employer from passing to the employee/applicant the cost of furnishing <b>any records</b> required by the employer as a condition of employment. This includes background checks, drug screening, etc.</p>

<p>For an Ohio employee, we must obtain a Central Registry check from the state. However, state law requires that those checks only be provided to third party agencies for adoption, foster care or for child care agencies. I have sent two requests and the second one with a self-addressed stamped envelope to the employee's home and have not received it back yet. What are our options when we have obtained an Ohio criminal check and Ohio OIG check and Ohio Nurse Aid Registry check? Do I not hire staff from Ohio and must I terminate my two Ohio employees?</p>	<p>If the agency can show that the state in question will not provide the information, then the agency will not be penalized.</p> <p><i>There are a number of states who will not provide a CAN check and/or a Central Registry Check. Each state must follow its own policies, procedures and statues. When this situation arises, we have asked the SCL provider to document their attempt to obtain the background check in the employees' personnel record in lieu of the out of state check. Documentation may include but is not limited to: email or snail mail correspondence with governmental officials of the other state; information printed from the other state's website, or a screen shot of the other state's website. As long as a provider can produce documentation that they have unsuccessfully attempted to obtain the out of state check, DDID will accept the documentation in place of the out of state check.</i></p>
<p>Is there a timeframe for new hire out of state background checks (Case Managers &amp; Employees)?</p>	<p>Out of state background checks must be completed within the same timeframes as in-state (Kentucky) background checks. This can be found in regulation here: (907 KAR 12:010) 3(3) (x) 1-3. Please also reference the question in this section regarding required documentation when another state's policy prevents the completion of out of state background checks.</p>

<p>Is the training for employees under SCL2 applicable for natural supports as well?</p>	<p>Personnel and training requirements listed in Section 3 of the SCL regulation (907 KAR 12:010) applies to agency employees and volunteers, not natural supports. If a person-centered team determines that training for friends, acquaintances, or co-workers providing natural supports is needed, the person centered team should develop Natural Support Training in accordance with the SCL regulation (907 KAR 12:010) 4(12)(a)1-9. This is a billable service; specific details of the payment limit can be found in the SCL Payment Regulation (907 KAR 12:020) 3(11).</p>						
<p>People have had many counselors that fit into the LPCA certification and are no longer able to receive services from those clinicians not having their LPCC certification; is there a possibility to grandfather some of those providers in?</p>	<p>No, a Licensed Professional Counselor Associate (LPCA) cannot provide Consultative Clinical and Therapeutic Services other than as a Positive Behavior Support Specialist. The SCL2 regulation includes a specific listing of acceptable credentials; LPCA is not included. In fact, an LPCA may be operating outside his or her scope of practice in providing Psychological Services under SCL1. An LPCA must work under clinical supervision cannot administer psychological testing, evaluation, diagnosis, or treatment.</p> <p>Related Regulations:</p> <p>SCL1: Section 4. Non-CDO Covered Services (j) Psychological services which shall: 1. Be provided to an SCL recipient who is dually diagnosed to coordinate treatment for mental illness and a psychological condition; 2. Be utilized if the needs of the SCL recipient cannot be met by behavior support or another covered service; 3. Include: a. The administration of psychological testing; b. Evaluation; c. Diagnosis; and d. Treatment;</p> <p>SCL2:</p> <table border="1" data-bbox="541 1146 1923 1390"> <tr> <td data-bbox="541 1146 886 1221">4(8)</td> <td data-bbox="886 1146 1923 1221">(8) A consultative clinical and therapeutic service shall:</td> </tr> <tr> <td data-bbox="541 1221 886 1317">4(8) (a)</td> <td data-bbox="886 1221 1923 1317">Be provided by a person who meets the personnel and training requirements established in Section 3 of this administrative regulation; and</td> </tr> <tr> <td data-bbox="541 1317 886 1390">4(8) (b)</td> <td data-bbox="886 1317 1923 1390">Is a:  1. Certified nutritionist;</td> </tr> </table>	4(8)	(8) A consultative clinical and therapeutic service shall:	4(8) (a)	Be provided by a person who meets the personnel and training requirements established in Section 3 of this administrative regulation; and	4(8) (b)	Is a:  1. Certified nutritionist;
4(8)	(8) A consultative clinical and therapeutic service shall:						
4(8) (a)	Be provided by a person who meets the personnel and training requirements established in Section 3 of this administrative regulation; and						
4(8) (b)	Is a:  1. Certified nutritionist;						

	<ol style="list-style-type: none"> <li>2. Licensed dietitian;</li> <li>3. Licensed marriage and family therapist;</li> <li>4. Licensed professional clinical counselor;</li> <li>5. Licensed psychological associate;</li> <li>6. Licensed psychologist;</li> <li>7. Licensed psychological practitioner;</li> <li>8. Licensed clinical social worker; or</li> <li>9. Positive behavior support specialist;</li> </ol>
<b>DSP CREDENTIALING AND CONTINUING EDUCATION RELATED QUESTIONS</b>	
<p>Pertaining to the continuing education required for professional staff that is in new regulations/policy manual- Can the hours include trainings like Crisis prevention, focus tool, CM, big day training, PDS training...or does it have to be something above and beyond those trainings offered by DDID and/or from an outside company or business.</p>	<p>The 6 hours of ongoing professional development must be trainings or professional development opportunities other than those required in regulation or required by DDID. Therefore, the DDID Crisis Prevention and Intervention training, Case Management trainings, Phase I and II College of Direct Support (CDS) modules, DDID Medication Administration trainings are not eligible to count as ongoing professional development. In addition, training such as First Aid and CPR which require annual updates are not eligible nor are trainings required by the agency such as policies/procedures, orientation, as well as PDS trainings required by the individual or any required training necessary to support an individual. Training required for PDS services that are designated in the regulation are not eligible to count for ongoing development.</p> <p>However, things that would count for ongoing professional development are CDS modules not required in Phase I or II training; trainings offered by the agency either from internal or external resources on topics that assist in provision of supports to multiple individuals supported by the agency; trainings offered by DDID either through webinars, modules, or face-to-face methods on a variety of topics including DSP Credentialing which are not required in regulation; conferences such as APSE, TASH, AAIDD, NADD, or SPEAK; or seminars or other educational opportunities offered by associations, agencies, etc. which are applicable to a staff member's role and responsibilities. For professional staff, such as case managers or positive behavior support specialists who have specific topics designated in the regulation, they may attend professional conferences, trainings, or events related to those topical areas.</p> <p>There are several web-based trainings available from outside sources as well as agencies who offer ongoing</p>

	<p>professional development which may carry a cost to the individual or agency. Please do not hesitate to contact <a href="mailto:Barb.Locker@ky.gov">Barb.Locker@ky.gov</a> if you have questions regarding a specific training and it's applicability for credit of ongoing professional growth.</p>
<p>What is 'documentation of completion of the expanded requirements for the direct support professional credentialed in the area of positive behavior supports?' Says we need that in our cover letter for exceptional supports.</p> <p>Should that be considered "as applicable"? I have not heard this defined further so any clarification would be awesome!</p>	<p>As noted in the Exceptional Supports Protocol (ESP) protocol, if an individual's needs are such that staff (specifically Direct Support Professionals) implementing exceptional behavioral health or behavioral supports require specialized training in the area of positive behavior supports, it is expected the DSP is appropriately trained to provide the specialized services for that individual. The expanded requirements for DSPs credentialed in the area of positive behavior support may be met by completing the Kentucky Direct Support Professional Specialty in Positive Behavior Support (DSP-SPBS) Credential available through DDID or an equivalent national credential as referenced in the KY DSP-SPBS Application Packet. Documentation that a DSP has met those requirements would be the actual copy of the current credential issued to the DSP by the appropriate credentialing agency (DDID, NADD, or NADSP). This is an "as applicable" component of the ESP.</p> <p>You may download a copy of the Application Packet for the KY DSP Specialty in PBS at: <a href="http://dbhdid.ky.gov/ddid/scl-training.aspx">http://dbhdid.ky.gov/ddid/scl-training.aspx</a></p> <p>The Application for DSP-SPBS contains the qualifications necessary for a DSP to attain a DDID issued credential through education, experience, or having attained an equivalent national credential. If the DSP seeks to attain a DDID issued credential based upon experience, the competencies and skills the DSP must demonstrate in a portfolio are outlined.</p>
<p>Are there any changes in staff credentialing due to a lack of providers being able to provide such services as Community Access? If not what is the direction if there are not enough providers offering the service to cover the demand? Not a lot of providers, if any, are</p>	<p>Thus far, there has not been clear evidence of a shortage of providers for Community Access (CA). The DDID online provider directory lists agencies that plan to offer the service. Current CLS staff employed prior to 1-1-14 are able to provide Community Access Services if they pursue and complete a credential within one year.</p>

<p>offering Community Access in central KY or rural areas... does the Department have a list of providers authorized/approved or currently providing those supports?</p>	
<p>Can a provider, without a degree or 5 years experience, who is hired after 1-1-14, pursue credentialing prior to providing CA?</p>	<p>An individual hired on or after 1-1-14 who does not meet the educational or 5 years' experience may seek a credential at any point for CA. They will not be held to a timeframe such as those employed prior to 1-1-14. They must have a minimum of 1 year of I/DD experience to be eligible to seek a credential and they must demonstrate proficiency in the competencies and skills for the CA Specialty Credential. The credential replaces the degree. Until they receive the credential, they will not be eligible to provide CA Specialist functions.</p>
<p>After 1-1-14 what are the qualifications to provide CA?</p>	<p>On or after 1-1-14, the qualifications to provide Community Access are stipulated in the regulation: 907 KAR 12:010 Section 1.</p>
<p>This is what is on the streets per regulatory representation: 3) After 1-1-14 the qualifications to provide CA is that you have to have Bachelor's degree. Years' experience and credentialing no longer apply. Is this true?</p>	<p>This is false. You must have a Bachelor's degree in Human Services; or a Bachelor's Degree in any program of study plus one year of experience in I/DD; or relevant experience or credentialing will substitute for the education requirement on a year-for-year basis. Here are a couple of brief examples which may help:</p> <p><b>Example 1:</b> An individual may have completed an Associate Degree in Human Services program at Jefferson Community College and then worked at Agency A providing relevant CA type supports for three years. Therefore, they would be qualified for the CA Specialist position.</p> <p><b>Example 2:</b> A potential candidate for a position as CA Specialist at Agency A has 2 years relevant (full-time) experience in I/DD. You want to employ them and they are ambitious. You may employ them as a DSP and they begin completing the credential program which takes them less than a year to develop and submit their portfolio and receive their credential as a DSP-SCA. The effective date of their credential is the date they are eligible to provide CA services as a CA-Specialist. At that point, you may transition them to that position within the agency.</p>
<p>If staff employed prior to 1/1/2014 do not currently have the education requirements, will they be able to provide CA services</p>	<p><b>The following are three examples of a person in this situation with comments:</b></p> <p><b>Staff A = total of 6.2 years relevant experience</b></p> <ol style="list-style-type: none"> <li>1. 3 months of providing CLS supports through an agency</li> <li>2. Direct Support Provider in Community Living Supports (CLS from 10/10 - 06/13 (2.8 years)</li> </ol>

<p>while they pursue credentialing?</p>	<ol style="list-style-type: none"> <li>3. Art teacher/direct support provider at day program from 02/12 - 06/13 (1.4 years)</li> <li>4. Direct Support Provider (CLS) for CDO client with ID 05/12 - 06/13 (13 months)</li> <li>5. Peer Tutoring in a special needs class daily during senior year of high school 08/08 - 06/09 (10 months)</li> </ol> <p><b>Staff resume will need to clearly demonstrate relevant experience. For example, what was done during the 10 month period of Peer Tutoring that is relevant to Community Access? If the resume supports this, Staff A meets the regulatory requirements for the provision of Community Access. However, if the resume does not clearly demonstrate relevant experience, the staff member must obtain a credential prior to 12/31/14 to continue in the role of CA Specialist.</b></p> <p>Staff B = 1.5 years of experience and 3 years of college</p> <ol style="list-style-type: none"> <li>1. 7 months providing CLS supports through the agency</li> <li>2. 3 years of College towards Bachelor's Degree in <a href="#">Social Work</a> (will graduate 5/2015)</li> <li>3. 10 month experience inside classroom with people with IDD.</li> </ol> <p><b>Staff B is 6 months short of relevant experience requirement. Staff B must obtain a credential to serve in the role of CA Specialist.</b></p> <p>Staff C= 1 to possible 7 years of relevant experience</p> <ol style="list-style-type: none"> <li>1. 1 year providing CLS supports with an agency</li> <li>2. 6 years of supports for a sibling with intellectual disability</li> </ol> <p><b>Six years of experience providing supports for a sibling must have been attained beginning from the age of 18 and must be relevant to Community Access services. The resume must clearly demonstrate relevant experience beginning at the age of 18. If the resume supports this, then Staff C does not require a credential. However, if the resume does not clearly demonstrate relevant experience beginning at the age of 18, Staff C must obtain a credential prior to 12/31/14 to continue in the role of CA Specialist.</b></p>
<p><b>QUALIFICATIONS</b></p>	
<p><b>Scenarios</b></p>	
<p><b><u>COMMUNITY ACCESS SPECIALIST</u></b></p>	
<ul style="list-style-type: none"> <li>• Staff A has been employed in the field of I/DD for 5 or more years providing <b>relevant</b> community</li> </ul>	

	<p>access type services. Staff A meets requirements to fulfill the role of Community Access Specialist on or after 1/1/14.</p> <ul style="list-style-type: none"> <li>• Staff B has an Associate Degree from a KCTCS institution in Human Services and has been employed in the field of I/DD for 3 or more years providing <b>relevant</b> community access type services. Staff B meets requirements to fulfill the role of Community Access Specialist on or after 1/1/14.</li> <li>• Staff C has an Associate Degree from a KCTCS institution in Human Services and has been employed in the field of I/DD for 1 year providing <b>relevant</b> community access type services. Staff C has been employed with ABC Agency since 11/1/13. Staff C must obtain either a KY DSP-Specialty in Community Access or a national equivalent credential by December 31, 2014 to continue in the role of Community Access Specialist.</li> <li>• Staff D has 1 year of experience in the field of I/DD and has been providing relevant community access services at ABC Agency since July 1, 2013. Staff D must obtain either a KY DSP-Specialty in Community Access or a national equivalent credential by December 31, 2014 to continue in the role of Community Access Specialist.</li> <li>• Staff E was employed by ABC Agency on 1/2/14 and has 1 year of experience in the field of I/DD. Staff E must obtain a KY DSP-Specialty in Community Access or a national equivalent credential before being placed in the role of Community Access Specialist. Until the credential is attained, Staff E must be employed as a DSP whose role and responsibilities does not require a degree or 5 years relevant experience.</li> </ul>
<p><b><u>SUPPORTED EMPLOYMENT SPECIALIST</u></b></p>	
	<ul style="list-style-type: none"> <li>• Staff A has been employed as a Job Coach in the field of I/DD for 5 or more years providing <b>relevant</b> supported employment services. Staff A meets the requirements to fulfill the role of Supported Employment Specialist on or after 1/1/14.</li> <li>• Staff B has been employed in the field of I/DD for 6 or more years providing <b>relevant</b> supported employment services. Staff B meets the qualifications to fulfill the role of Supported Employment Specialist on or after 1/1/14; but must complete the HDI Supported Employment Training Project</li> </ul>

	<p>training within 6 months of the date he/she begins providing Supported Employment services.</p> <ul style="list-style-type: none"> <li>• Staff C has an Associate Degree from a KCTCS institution in Business Administration and has been employed in the field of I/DD for 3 or more years providing Job Coach responsibilities. Staff C meets the requirements to fulfill the role of Supported Employment Specialist on or after 1/1/14.</li> <li>• Staff D has an Associate Degree from a KCTCS institution in Business Administration, has been employed at ABC Agency since June 1, 2013 providing Job Coach related duties, and has attended the HDI Supported Employment Training Project training. Staff D must obtain either a KY DSP-Specialty in Employment Services or a national equivalent credential in Supported Employment by December 31, 2014 to continue in the role of Supported Employment Specialist.</li> <li>• Staff E has 1 year of experience in the field of I/DD providing <b>relevant</b> supported employment services at ABC Agency since February 1, 2013 and has completed the HDI Supported Employment Training Project training. Staff E must obtain either a KY DSP-Specialty in Employment Services or a national equivalent credential in Supported Employment by December 31, 2014 to continue in the role of Supported Employment Specialist.</li> <li>• Staff F was employed by ABC Agency on 1/15/14, has 1 year of experience in the field of I/DD and has completed 12 hours of college coursework. Staff F must obtain a KY-DSP-Specialty in Employment Supports or a national equivalent credential before being placed in the role of Employment Support Specialist. Until the credential is attained, Staff F must be employed as a DSP whose role/responsibilities does not require a degree or 5 years relevant experience.</li> </ul>
<p>Can a syllabus be used as a work sample? For example, if the class someone took required them to complete work that was relevant to the</p>	<p>No, a syllabus alone is not an acceptable work sample. If the individual is completing course work, then the work product submitted for a grade would be an acceptable work sample with the appropriate reflective summary.</p>

<p>credential they were trying to obtain?</p>	
<p>Under option B that requires you to have 18 months of experience – can that be volunteer experience or does it need to be from a paid position? Does it need to be at one employer?</p>	<p>We have revised some of the qualifications under all the requirements. Relevant experience (paid or volunteer) attained from the age of 18 may be appropriate. It would not have to be from the same employer or volunteer agency.</p>
<p>1.) Since official transcripts come in a sealed envelope, people were asking if they will still be considered official once they open the envelope and scan them into the computer?</p>	<p>Requirements are that we have a copy of an official transcript. So once they are scanned into the file then they will be considered official for our purposes</p>
<p>Where are the checks and balances regarding work samples that are submitted? How will you know at DDID that someone actually did what they said they did and wrote about in the work sample and reflective summary versus just</p>	<p>First, we place high value on the honor system. If the DSP did not do the work, then they should not “make up” something just to get a credential. The resume should demonstrate that the individual worked in a setting that would be conducive and expected for the work sample provided. We will be asking Quality Administrators for input, especially if the work sample does not appear reasonable or realistic. In addition to our QA staff, we will like spot check with employers/supervisors as we review documents.</p>

making something up and submitting it.	
<p>If someone completed a credential and then it no longer existed such as the Person Centered one, would it still be recognized that the individual had the credential.</p> <p>.</p>	<p>If we issue a credential that is discontinued in the future, it will be recognized while it is in effect. At time for renewal, the DSP will need to determine what other credential offered by DDID or a national organization is applicable to apply for.</p>
<b>SUPPORTED EMPLOYMENT RELATED QUESTIONS</b>	
<p>We are being told conflicting information about SE. We are getting LOIs stating that we need to send a VR exhausting letter. However, we have been told by DDID that we no longer need this letter just the SE plan. Please clarify and clarify with Carewise?</p>	<p>Supported Employment planning and activity forms are now available on our web page: <a href="http://dbhdid.ky.gov/ddid/scl-forms-employment.aspx">http://dbhdid.ky.gov/ddid/scl-forms-employment.aspx</a></p> <p>The Long-term employment support plan is created at the end of the Job Acquisition and Training Phase of Supported Employment, immediately before OVR pays the outcome fee to the provider. It is literally the last thing that is done before long term supports begin. For this reason, it is always proof that OVR funding has been exhausted when presented in conjunction with a request for Long-Term Employment Supports and should, in fact, provide justification for additional supports when more than 24 units per month of long term supports are requested.</p> <p>If Person Centered Job Selection, Job Development and Analysis, or Job Acquisition with Training is to be requested after a participant has received long term supports, the person-centered team should contact Jeff White at <a href="mailto:Jeff.White@ky.gov">Jeff.White@ky.gov</a> immediately. Jeff will work with OVR staff to determine the appropriate stream of funding and communicate that information to CareWise Health.</p> <p>An individual may have a Long Term Supported Employment Plan and a Person Centered Employment Plan.</p> <p>Should an individual working in the community and receiving long term supports decides they would like to have a different or better job, they can continue to receive long term supports while working with an employment specialist to find a new job. It is much easier for anyone to find a new job when they already have a job.</p>

Type of Supported Employment	Additional Documentation to be Sent to Carewise Health	
Long-Term Employment Supports	<p><b>24 units per month or less:</b> Written Identification of the participant’s workplace and normal hours of work.</p> <p><b>More than 24 units per month:</b> Updated copy of the Long Term Employment Support Plan justifying the quantity of Long-term supports requested, written identification of the participant’s workplace, and normal hours of work.</p>	
Person-Centered Job Selection	No additional documentation required beyond the information referenced in the next column.	<p>An official letter from DDID, OVR, or Office for the Blind confirming that all alternative streams of funding have been exhausted and the Medicaid Waiver is the appropriate funder of last resort.</p> <p>Please Contact DDID (<a href="mailto:jeff.white@ky.gov">jeff.white@ky.gov</a>) to begin the process for receipt of the letter very early in the person-centered planning process.</p> <p><b>The identification of the proper funding stream often requires several weeks.</b></p>
Can you tell us about the APSE Pre-conference sessions for case managers in February?	<p>On February 12th from 10:00 am until 4:00 pm Case Managers and Employment Specialists from all around Kentucky have the opportunity to meet together with Rehabilitation Counselors in an effort to help these very important parties learn exactly what should be expected from each other. In addition, opportunities will exist to have questions addressed by applicable DDID, OVR, or UK-HDI staff. The day will end with locally-oriented facilitated breakout sessions geared to help each group develop a well-informed plan to work together into the future.</p> <p>On February 13th conference attendees and program participants will have the opportunity to enjoy a keynote address by America’s Leading Sit-down- Standup Comedian, Brett Leake. Mr. Leake, a frequent guest on The</p>	

	<p>Tonight Show, refuses to let the fact that he has a significant disability get in the way of making people laugh. Mr. Leake’s critically acclaimed, “A Funny Thing Happened on the Way to the ‘Tonight Show’” accomplishes this with a bit of motivation thrown in for good measure.</p> <p>As an extra treat, Mr. Leake will be holding a workshop for everyone, providers and those seeking employment. It will include take aways from his keynote. The stories will focus on how to communicate your needs that other people, without disabilities, may not be at first aware. It will be a deeper exploration, with plenty of humor, of communicating on the job and in different parts of life. Brett is now able to assist other people with disabilities on the job and will share how his humor has allowed him to help others and create successful situations for all. (Note: Be prepared to learn and to laugh throughout.) A special ½ day rate of \$15 has been established to enable program participants to take advantage of this opportunity. (The conference favor is likely to cost nearly \$15 by itself!)</p> <p>The conference continues on February 13th with concurrent sessions dealing with theme tracks covering: Quality Services: How To, Transition Services &amp; Employment, Mental Illness &amp; Employment, Criminal Justice &amp; Re-entry Services, and Waiver Services &amp; Supported Employment. There should be ample opportunity to meet the SCL continuing education requirement during this single conference. CRC credits are also available.</p> <p>On February 14th, help move employment forward in Kentucky by taking advantage of the special First-Time Introductory APSE membership offer of \$75 and get immediately involved in our membership breakfast and meeting. The conference concludes with Kentucky Supported Employment Visionary Carol Estes returning to the podium for the closing session. One can always expect Carol to congratulate us for things we have done well, inform us of thing we should have done better, and challenge us to set our sights higher.</p> <p>Following the Conference your employment services staff could take advantage of the opportunity to sit for the CESP exam and establish their credentials as Employment Specialists.</p>
<b>Case Management Supervisory Training</b>	
Do old Case Management Supervisors who have been with the agency for an extended period of time have to watch these	Yes, all existing Case Management Supervisors, regardless of years of experience are required to complete this DDID approved curriculum. New CM Supervisors within 6 months of taking the position. Existing CM Supervisors within 6 months of the training being made available, this was 2/11/14.

modules and take the tests?	
Does the new SCL2 CM Supervisor's Training module replace the CFSM Your First Few Weeks module? Or would supervisors need to complete both?	The Case Management Supervisors Training is the approved DDID curriculum that is required specifically for Case Management Supervisors per new regulation. It must be completed regardless of other management modules he/she may have previously completed or is currently assigned.
We do not provide Case Management at our agency, do I need to take the Case Management Supervisor's training?	No, if you do not provide Case Management at your agency, you do not have to ensure someone at your agency takes it.