COMMUNITY BASED SERVICES, AFL AND PERIODIC POLICIES, PROCEDURES, AND OPERATIONS MANUAL

4/14
Revised 6/14

ALTERNATIVE FAMILY LIVING (AFL)
POLICIES, PROCEDURES, AND OPERATIONS

PURPOSE

Persons with intellectual and developmental disabilities have the inherent right to fulfill their potential as human beings and can be helped to lead dignified lives regardless of their level of functioning. The Alternative Family Living (AFL) was created to assist eligible persons to realize that potential, to provide an alternative to institutionalization and group home, and to provide the necessary level of care and services for eligible individuals to live in their home communities.

DEFINITION

Alternative Family Living Arrangement (AFL) - An out of home setting where the participant receives 24-hour care and lives in a private home environment with a family (or individual) where the services are provided to address the care and habilitation needs of the participant. Any AFL providing services to a child/children or two or more adults requires a license (as defined by NC General Statues 122C-3 27G .5600F). Waiver funding may not be utilized as payment for room and board costs. The MCO and Innovations care coordinator jointly monitor the health and safety of the person.

POLICY

1. The Alternative Family Living Arrangement is monitored by Macon Citizens Habilities, Inc., and is referred to herein as the AFL.

See Attachment 1 -- AFL Monitoring Form
See Attachment 2 – DHHS Unlicensed AFL H&S Review Tool

2. The AFL provides individuals with I/DD who are eligible for Innovations Residential Supports and suitable for a family-style living arrangement in a community setting with residential placement.
3. Priority is given to citizens of Macon, Jackson, Swain, Clay, Cherokee, Graham, and Haywood Counties, or the catchment area of the Smoky Mountain Managed Care Organization.
4. Clients and families are made aware of provider choice at least annually.
5. Innovations addresses the needs of individuals in their community, insures person-centered planning for each individual, provides for simplicity and ease of service delivery, promotes movement of individuals to the community from intermediate care facility for persons with mental retardation (ICF-MR) group homes and state developmental centers, and is a Medicaid community care funding source for persons with mental retardation/developmental disabilities. It offers specific services in the community for individuals of all ages who require an ICF-MR level of care and gives a cost-effective alternative to care in an ICF-MR.
6. MCH is responsible for maintaining a current license to operate, internal quality improvement plans, and maintaining a client's rights committee.

PROCEDURES

1. The AFL provides services according to the principles of normalization and person-centered planning with a positive, person-centered approach to habilitation.
2. A person with mental retardation/developmental disabilities may be *considered* for Innovations funding and placement in the group home if *all* of the following criteria are met:
   (a) The individual meets the requirements for ICF-MR level of care.
   (b) The individual is eligible for Medicaid coverage or will be eligible for Medicaid under the Innovations eligibility criteria.
   (c) The individual resides in an ICF-MR facility or is at high risk of being placed in an ICF-MR facility.

(d) The individual's health, safety and well-being can be maintained in the community under the program.
(e) The individual requires Innovations services, based on medical necessity criteria, as identified through a family or person-centered planning process. An individual must require at least one waiver service as identified in the person-centered planning process and indicated in the Plan of Care and Cost Summary.
(f) The person-centered planning process assists the individual with their family or guardian in identifying and accessing a personalized mix of paid and non-paid services that will assist him/her to achieve personally defined outcomes in the most inclusive community setting.
(g) The individual, his/her family, and/or guardian desire Innovations participation rather than institutional services.

3. The AFL promotes a family-like atmosphere and provides the training necessary to help the consumer become as independent as possible. The consumer(s) is assisted to develop skills which allow for self-sufficiency, independence, and social acceptance in the community.
4. Consumer(s) who lives in the AFL and/or the representative/legal guardian must enter into an agreement or contract for services with MCH.
5. At least annually provider choice will be reviewed with the consumer and guardians. If a change is desired, assistance will be offered to find a more suitable provider.

See Attachment 3 - AFL/Consumer/Guardian Agreement

INNOVATIONS AFL DOCUMENTATION

POLICY

MCH must document the provision of the Innovations service before seeking Medicaid payment. Services shall be documented in accordance with the Service Records Manual for Providers of MH/DD/SAS Services. Lead Agencies and Provider Agencies must also keep related personnel, financial and other management records as required.

The records must be maintained for 5 years from the date of service.

MCH must furnish information regarding its Medicaid payments as requested by the MCO and its agents, DMH/DD/SAS (including the local lead agencies), the Office of the Attorney General, the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, and any other entities specified in the Medicaid Provider Participation Agreement.

In addition, MCH must allow the Innovations care coordinator, lead agency staff, DMH/DD/SAS, DMA, and/or CMS to review the documentation that supports a claim for Innovations services rendered and billed. MCH must bring/mail documents to designated sites during state and/or federal reviews.

PROCEDURES

1. Innovations Residential Supports is documented on a grid or form designed to identify the goal(s) being addressed along with a key which specifies the intervention/activity provided and a separate key which reflects the assessment of client progress toward goal(s) during that episode of care. The grid must include:
   (a) name of the individual
   (b) record number
   (c) Medicaid ID number
   (d) the full date the service was provided (month/day/year)
   (e) the goals that are being addressed
   (f) a number or letter as specified in the key which reflects the intervention/activity
   (g) a number or letter as specified in the key which reflects the assessment of the consumer's progress toward goals

(h) duration, when required
(i) initials of the individual providing the service. The initials shall correspond to a signature on the signature log section of the grid.
(j) The grid shall provide space where additional information may be documented as needed.

2. Residential Supports is a blended service that includes habilitation, personal care and support; therefore, all areas must be addressed. Elements noted in the grid address the habilitation area. Personal care and support may be addressed by using a grid, checklist, or a daily note.
3. The completion of the grid to reflect services provided shall be documented within 24 working hours.
4. If a service note or grid is documented after the required 24 working hours, it shall be considered a *late entry*. The entry shall be noted as a *late entry* and at a minimum the date the documentation was made and the date for which the documentation should have been documented. For example, *Late entry made on 4/15/03 for 4/12/03*.
5. Whenever corrections are necessary in the consumer's paper record, the following procedures are to be followed:
   (a) the person who recorded the entry must make the correction
   (b) draw one single thin line through the error or inaccurate entry, making certain the original entry is still legible
   (c) record the corrected entry legibly above or near the original entry
   (d) record the date of the correction and initials of the recorder. An explanation as to the type of documentation error shall be included whenever the reason for the correction is unclear (e.g. *wrong consumer record*, *transcription error*)
   (e) whenever omitted words cannot be inserted in the appropriate place above the record entry, the information should be made after the last entry in the record. Never "squeeze" additional information into the area where the entry should have been recorded.
6. Correcting fluid or tape shall not be used for correction of errors.
7. All entries in the service record shall be signed. Professional staff must sign name with credentials, degree, or licensure. Paraprofessionals should sign name and position (e.g. *Jane Doe, HA*.)

See Attachment 4 – AFL GRID

INNOVATIONS STAFF QUALIFICATIONS/REQUIREMENTS

1. The AFL provider must undergo and meet the following requirements:
   (a) criminal record check including fingerprinting if the individual has not lived in NC for the past 5 years
   (b) healthcare registry check and no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry
   (c) clean driving record if providing transportation to clients
   (d) at least 21 years of age
   (e) able to read, write, understand and follow directions
   (f) disclose any criminal conviction
   (g) be currently licensed, registered or certified in accordance with applicable state laws for the services provided
   (h) demonstrate knowledge, skills and abilities required by the population served
   (i) trained in client specific competencies to be met as identified by the individual's person-centered planning team and documented in the plan of care.
   (j) Meet the qualifications for a paraprofessional in 10A NCAC 27 G. 0100 – 0200.
2. A minimum of 1 trained staff member shall be present at all times when any adult client is on the premises.
3. Staff competence shall be demonstrated by exhibiting core skills including technical knowledge, cultural awareness, analytical skills, decision-making, interpersonal skills, communication skills, clinical skills
4. Training is documented and maintained by the HR Manager.

MEDICAL/EMERGENCY PREPAREDNESS

1. The AFL provider shall be trained in CPR and first aid which must be kept current and documented in the provider's file. There shall be an Emergency Action Plan readily available.
2. In the event of a medical emergency, the provider must call 911 and proceed with training skills learned in CPR and first aid until medical responders arrive.
3. In the event, the situation does not require immediate action, the provider should contact the primary physician, use Angel Urgent Care or Angel Medical Services Emergency Room.

CRISIS SERVICES

1. If gas or propane is used in the home or anyone smoke in the home, there must be a CO_2 monitor in the home.
2. AFL provider must be trained in crisis intervention and document crisis training on the fire drill record.
3. A crisis plan shall also be part of the Innovations Waiver ISP for the client.
4. If another person lives in the home, this would be first in line as back up staff, if trained.
5. If the backup person is not Innovations trained, he/she cannot do documentation on goals. However, they should write a progress note.
6. If necessary, the MCH PRN pool may also be used.

PERSONAL CARE SERVICES

Personal Care Services under North Carolina State Medicaid Plan differs in service definition and provider type from the services offered under the waiver. Personal Care Services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging the participant describes the flexibility of activities that may encourage the participant to maintain skills gained during habilitation while also providing supervision for independent activities. *This service may include preparation of meals, but does not include the cost of the meals themselves.*

When specified in the ISP, this service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the participant, rather than the participant's family. Personal care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation, and use of special mobility devices. Personal Care Services may be provided outside of the private home as long as the outcomes are consistent with the support described in the ISP. Services may be allowed in the private home of the provider, staff or an Employer of Record, or staff of an Agency With Choice if there is documentation in the ISP that the participant's needs cannot be met in the participant's private home or another community location.

EXCLUSIONS:

- Personal Care Services do not include medical transportation and may not be provided during medical transportation and medical appointments.
- Participants, who live in licensed residential facilities, licensed AFL homes, licensed foster homes, or unlicensed alternative family living homes serving one adult, may not receive any aspect of this service or any other State Plan Personal Care Service.
- Personal Care cannot be provided in a licensed program.
- This service may not be provided on the same day that the participant receives State Plan Medicaid Respite, a home health aide visit, Residential Supports or another substantially equivalent service.
- This service may not be provided at the same time of day that a participant receives Day Supports, Community Networking, In-Home Intensive Support, In-Home Skill Building, and Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person.
- The service does not cover the staff member completing home maintenance, housekeeping for areas that are used by other members of the household and/or meal preparation when the same meal is being prepared for other family members.
- For participants who are eligible for educational services under the Individuals With Disability Educational Act, personal care does not include transportation to/from school settings. This includes transportation to/from the participant's home, provider home where the participant may be receiving services before or after school or any other community location where the participant may be receiving services before or after school. Transportation between the participant's home and the provider's home is not billable service time.
- Personal Care cannot be billed during official school hours. This does not include holidays or snow days.
- Personal Care Services cannot to drop off or pick up a school aged child at school.

LIMITS ON DURATION, AMOUNT OR FREQUENCY

The amount of Personal Care Services is subject to the limits on sets of services specified in *Appendix M of the Innovations Technical Manual. The amount of Personal Care Services also is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.

SERVICE DELIVERY METHOD

Provider Directed and Approved as a provider in the PIHP provider network – MCH is the provider agency.

Agency staff that work with participants:

- Are at least 18 years of age
- If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance (Bodily injury $100,000 each person and $300,000 each accident).
- Criminal background check present no health and safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in CPR and First Aid
- Qualified in the customized needs of the participant as described in the ISP
- High school diploma or high school equivalency (GED)
- Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012.
- Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The individual, however, may select any enrolled Crisis Services provider in lieu of this provider.
- Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least 1 of designated accreditation agencies.
- The organization must be established as a legally constituted entity, capable of meeting all the requirements of PIHP.
- Services provided in the private home of the direct service employee are subject to the PIHP Health and Safety assurances checklist and monthly monitoring by the Employer of Record or provider agency Qualified Professional. MCH does not provide personal care in the staff home.

PERSONAL CARE ADMISSIONS/DISCHARGE

POLICY

1. All applicants must:
   (a) Be approved by the MCH Admissions Committee prior to admission.
   (b) Have the Innovations Waiver.
2. Personal Care serves individuals who meet the following criteria:
   (a) intellectual and developmental disabilities
   (b) eligible for ICF-IID level of care as documented on an **LOC** approved by a physician or clinical psychologist and SNAP
   (c) resident of the state of NC
   (d) at least **5** years of age or older
   (e) approved ISP with Personal Care
3. Applicants are screened based on at least 3 deficits in level of care or the NC SNAP and ICF-IID level of care. The level of care should include an IDD diagnosis. Other evaluations such as psychological and intelligence tests may also be used in screening.
4. In order to be meet LOC, the applicant is screened to determine if he/she meets the following criteria:

(a) have a diagnosis of intellectual and developmental disabilities (per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition, Intelligence Quotient (IQ) test results indicating intellectual and developmental disabilities, **or**

(b) a condition that is closely related to intellectual and developmental disabilities. Intellectual and developmental disabilities is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability must manifest before age 22. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets **ALL** of the following conditions: a. is attributable to cerebral palsy, epilepsy; **or** any other condition, other than mental illness, found to be closely related to intellectual and developmental disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. The related condition manifested before age 22 and is likely to continue indefinitely and have intellectual and developmental disabilities or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas (1) self-care (ability to take care of basic life needs for food, hygiene, and appearance), (2) understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally), (3) learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations). (4) mobility (ambulatory, semi-ambulatory, non-ambulatory), (5) self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life), (6) capacity for independent living (age-appropriate ability to live without extraordinary assistance). Reports by physicians, psychologists, and other appropriate disciplines are evaluated to determine whether an individual has a substantial functional limitation in a major life activity.

(c) Personal Care Services under North Carolina State Medicaid Plan differs in service definition and provider type from the services offered under the waiver. Personal Care Services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging the participant describes the flexibility of activities that may encourage the participant to maintain skills gained during habilitation while also providing supervision for independent activities. *This service may include preparation of meals, but does not include the cost of the meals themselves.*
When specified in the ISP, this service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the participant, rather than the participant's family. Personal care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation, and use of special mobility devices.

(d) Personal Care Services may be provided outside of the private home as long as the outcomes are consistent with the support described in the ISP. Services may be allowed in the private home of the provider, staff or an Employer of Record, or staff of an Agency With Choice if there is documentation in the ISP that the participant's needs cannot be met in the participant's private home or another community location. MCH does not allow Personal Care in staff homes.

5. There shall be no discrimination with regard to race, color, sex, religion, national origin, or political affiliation in considering placement. MCH complies with the Title VI (Civil Rights, 1964), Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.)
6. The applicant must be able to have needs met by MCH and must be able to participate in or more of the essential services in the definition. The client and/or legally responsible persons must agree to abide by the rules and regulations of the service definition.
7. The Admissions Committee shall consist of the following members:
   (a) Executive director
   (b) Program director
   (c) QP
   (d) RN
   (e) Care Coordinator
8. The Admissions Committee shall review all admissions.

DISCHARGE

POLICY

1. The discharge committee is made up of the same representatives as the admissions committee and shall have final determination when a client is discharged. Other consultants such as the psychologist, physical therapist, etc. may be included in the decision.
2. No client shall be discharged without a recommendation from the executive director, program director, and admissions/discharge committee.
3. Normally, the only the only reason for discharge would be the inability to meet the health and welfare of the Innovations recipient or noncompliance of a family/guardian.
4. In addition, MCH is responsible for letting the MCO know of an impending discharge and reasons for discharge.
5. The client or legally responsible person shall receive a copy of the discharge plan.
6. A client may be discharged if the client and/or family make a request for discharge.
7. Unless in the event of an emergency, the client or legal guardian(s) must receive 60 days' notice.

INNOVATIONS PCS DOCUMENTATION

POLICY

The minimum service documentation requirements for services provided through the NC Innovations Waiver are contained in this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2. Information concerning documentation of all Medicaid or State funded services not contained in the NC Innovations Waiver can also be found in the Records Management and documentation Manual 45-2.

Services must be documented by all Medicaid providers and done so prior to seeking Medicaid payment. There shall be follow-up documentation to reflect attempts to ascertain why a participant is not participating in a service/support in accordance with the established schedule or plan.

SERVICE NOTE

For Service Note requirements please refer to the Records Management and Documentation Manual (chapter 8 & 9) The following NC Innovation services require a full service note, which includes Items 1 through 13, under Contents of a Service Note, Chapter 8 of the Records Management and Documentation Manual.

A service grid shall be completed daily or per activity to reflect the service provided.

All entries in the service record shall be signed with a full signature. A full signature is to include the credentials, degree or licensure for professional staff or the position of the individual who provided the service for paraprofessional staff. Please refer to the Records Management and Documentation Manual 45-2 (Chapter 9) for signature requirements.

FREQUENCY OF SERVICE DOCUMENTATION

All NC Innovations services require a daily or per activity service note or grid. The person who provided the service shall write and sign the service note or grid. The service note or grid to reflect services provided shall be documented on the day that the service was provided or no later than the next workday. If a service note or grid is not documented on the day the service was provided, it shall be considered a "late entry."

Late entries are defined as those which are entered after the required time for documentation has expired. The entry shall be noted as a "late entry" and at a minimum the date the documentation was

made and the date for which the documentation should have been documented. For example, “Late Entry made on 2/15/12 for 2/14/12.” The late entry must include a dated signature. Service notes shall be made at the frequency necessary to indicate significant changes in the participant’s status, needs or changes in the Individual Support Plan.

CORRECTIONS IN THE SERVICE RECORD

Changes or modifications in the original documentation for the purpose of making a correction can be made at any time, when appropriate. Whenever corrections are necessary in the participant’s record, service providers should refer to the procedures as noted in the Records Management and Documentation Manual 45-2 (Chapter 9). However, for quality assurance and reimbursement purposes, all necessary documentation or corrections to support billing shall be properly completed within seven (7) working days. Therefore, for billing purposes, corrections must be made within this prescribed timeframe.

See Attachment 5 – PCS Grid

COMMUNITY NETWORKING SERVICE

Community Networking services provide individualized day activities that support the participant's definition of a meaningful day in an integrated community setting, with persons who are not disabled. This service is provided separate and apart from the participant's private residence, other residential living arrangement, and/or the home of a service provider. These services do not take place in licensed facilities and are intended to offer the participant the opportunity to develop meaningful community relationships with non-disabled individuals. Services are designed to promote maximum participation in community life while developing natural supports within integrated settings.

Community Networking services enable the participant to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community. As participants gain skills and increase community connections, service hours should fade; however a formal fading plan is not required.

Community Networking services consist of:

1. Participation in adult education;
2. Development of community based time management skills;
3. Community based classes for the development of hobbies or leisure/cultural interests;
4. Volunteer work;
5. Participation in formal/informal associations and/or community groups;
6. Training and education in self-determination and self-advocacy;
7. Using public transportation;
8. Inclusion in a broad range of community settings that allow the participant to make community connections; and/or
9. For children, this service includes staffing supports to assist children to participate in day care/after school summer programs that serve typically developing children and are not funded by Day Supports.
10. Transportation when the activity does not include staffing support and the destination of the transportation is an integrated community setting or a self-advocacy activity. Payments for transportation are an established per trip charge or mileage.

This service includes a combination of training, personal assistance and supports as needed by the participant during activities. Transportation to/from the participant's residence and the training site(s) is included. Payment for attendance at classes and conferences is also included**.**

EXCLUSIONS:

- This does not include the cost of hotels, meals, materials or transportation while attending conferences.
- This service does not include activities that would normally be a component of a participant's home/residential life or services.
- This service does not pay day care fees or fees for other childcare related activities.
- The service may not duplicate services provided under Community Guide,
- Day Supports, In-Home Intensive Supports, In- Home Skill Building, Personal Care, Residential Supports, and/or Supported Employment services.
- This service may not be furnished/claimed at the same time of day as Day Supports, In-Home Intensive Supports, In- Home Skill Building, Personal Care, Residential Supports, Respite, Supported Employment or one of the state plan Medicaid services that works directly with the participant.
- For participants who are eligible for educational services under the Individuals With Disability Educational Act, Community Networking does not included transportation to/from school settings. This includes transportation to/from participant's home or any community location where the participant may be receiving services before/after school.

- This service does not pay for overnight programs of any kind.
- Memberships of any type are not covered under this definition.
- Classes that offer one-to-one instruction and are in a nonintegrated community setting are not covered.
- The NC Innovations Waiver renewal, effective August 1, 2013, does not allow for Community Networking to be provided by individuals who are employed as "Relative as Provider." This means that family members currently providing this service will be approved to provide Community Networking.

LIMITS ON DURATION, AMOUNT OR FREQUENCY

Payment for attendance at classes and conferences will not exceed $1000/ per participant plan year. The amount of community networking services is subject to the "Limits on Sets of services" specified in Appendix M. The amount of community networking services is subject to
the amount of the participant's Support Need Matrix Category Budget as specified in Appendix C-4 if currently phased into the Support Needs Matrix.

SERVICE DELIVERY METHOD

Provider Directed and Approved as a provider in the PIHP provider network – MCH is the provider agency.

Agency staff that work with participants:

- Are at least 18 years old If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance
- Criminal background checks present
- no health and safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in CPR and First Aid
- Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP
- High school diploma or high school equivalency (GED)
- Paraprofessionals providing this service must be supervised by a qualified professional.
- Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204(b) (c) (f) and according to licensure or certification requirements of the appropriate discipline. Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012
- Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.
- The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

COMMUNITY NETWORKING ADMISSIONS/DISCHARGE

POLICY

1. All applicants must:
   a. Be approved by the MCH Admissions Committee prior to admission.
   b. Have the Innovations Waiver.

2. Community Networking services serves individuals who meet the following criteria:
   (a) intellectual and developmental disabilities
   (b) eligible for ICF-MR level of care as documented on an **LOC** approved by a physician or clinical psychologist and SNAP
   (c) resident of the state of NC
   (d) at least **5** years of age or older
   (e) approved ISP with Community Networking Services
3. Applicants are screened based on at least 3 deficits in level of care or the NC SNAP and ICF-MR level of care. The level of care should include an IDD diagnosis. Other evaluations such as psychological and intelligence tests may also be used in screening.
4. In order to be meet LOC, the applicant is screened to determine if he/she meets the following criteria:
5. have a diagnosis of intellectual and developmental disabilities (per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition, Intelligence Quotient (IQ) test results indicating intellectual and developmental disabilities, **or**
6. a condition that is closely related to intellectual and developmental disabilities. Intellectual and developmental disabilities is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability must manifest before age 22. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets **ALL** of the following conditions: a. is attributable to cerebral palsy, epilepsy; **or a**ny other condition, other than mental illness, found to be closely related to intellectual and developmental disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. The related condition manifested before age 22 and is likely to continue indefinitely and have intellectual and developmental disabilities or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas (1) self-care (ability to take care of basic life needs for food, hygiene, and appearance), (2) understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally), (3) learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations). (4) mobility (ambulatory, semi-ambulatory, non-ambulatory), (5) self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life), (6) capacity for independent living (age-appropriate ability to live without extraordinary assistance). Reports by physicians, psychologists, and other appropriate disciplines are evaluated to determine whether an individual has a substantial functional limitation in a major life activity.
7. Community Networking Services under North Carolina State Medicaid Plan differs in service definition and provider type from the services offered under the waiver. Community Networking Services under the waiver provide individualized day activities that support the persons served's definition of a meaningful day in an integrated community setting with persons who are not disabled.
8. Community Networking Services must be provided outside of the private home or residential living separate and apart from person's served private residence or other living arrangement and/or the home of a service provider.
9. There shall be no discrimination with regard to race, color, sex, religion, national origin, or political affiliation in considering placement. MCH complies with the Title VI (Civil Rights, 1964), Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.)
10. The applicant must be able to have needs met by MCH and must be able to participate in or more of the essential services in the definition. The client and/or legally responsible persons must agree to abide by the rules and regulations of the service definition.
11. The Admissions Committee shall consist of the following members:
12. Executive director
13. Program director
14. QP
15. RN
16. Care Coordinator

17. The Admissions Committee shall review all admissions.

DISCHARGE

POLICY

1. The discharge committee is made up of the same representatives as the admissions committee and shall have final determination when a client is discharged. Other consultants such as the psychologist, physical therapist, etc. may be included in the decision.
2. No client shall be discharged without a recommendation from the executive director, program director, and admissions/discharge committee.
3. Normally, the only the only reason for discharge would be the inability to meet the health and welfare of the Innovations recipient or noncompliance of a family/guardian.
4. In addition, MCH is responsible for letting the MCO know of an impending discharge and reasons for discharge.
5. The client or legally responsible person shall receive a copy of the discharge plan.
6. A client may be discharged if the client and/or family make a request for discharge.
7. Unless in the event of an emergency, the client or legal guardian(s) must receive 60 days' notice.

COMMUNITY NETWORKING DOCUMENTATION

POLICY

The minimum service documentation requirements for services provided through the NC Innovations Waiver are contained in this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2. Information concerning documentation of all Medicaid or State funded services not contained in the NC Innovations Waiver can also be found in the Records Management and Documentation Manual 45-2.

Services must be documented by all Medicaid providers and done so prior to seeking Medicaid payment. There shall be follow-up documentation to reflect attempts to ascertain why a participant is not participating in a service/support in accordance with the established schedule or plan.

SERVICE NOTE

For Service Note requirements please refer to the Records Management and Documentation Manual (chapter 8 & 9) The following NC Innovation services require a full service note, which includes Items 1 through 13, under Contents of a Service Note, Chapter 8 of the Records Management and Documentation Manual.

A service grid shall be completed daily or per activity to reflect the service provided.

All entries in the service record shall be signed with a full signature. A full signature is to include the credentials, degree or licensure for professional staff or the position of the individual who provided the service for paraprofessional staff. Please refer to the Records Management and Documentation Manual 45-2 (Chapter 9) for signature requirements.

FREQUENCY OF SERVICE DOCUMENTATION

All NC Innovations services require a daily or per activity service note or grid. The person who provided the service shall write and sign the service note or grid. The service note or grid to reflect services provided shall be documented on the day that the service was provided or no later than the next workday. If a service note or grid is not documented on the day the service was provided, it shall be considered a "late entry."

Late entries are defined as those which are entered after the required time for documentation has expired. The entry shall be noted as a “late entry” and at a minimum the date the documentation was made and the date for which the documentation should have been documented. For example, “Late Entry made on 2/15/12 for 2/14/12.” The late entry must include a dated signature. Service notes shall be made at the frequency necessary to indicate significant changes in the participant’s status, needs or changes in the Individual Support Plan.

CORRECTIONS IN THE SERVICE RECORD

Changes or modifications in the original documentation for the purpose of making a correction can be made at any time, when appropriate. Whenever corrections are necessary in the participant’s record, service providers should refer to the procedures as noted in the Records Management and Documentation Manual 45-2 (Chapter 9). However, for quality assurance and reimbursement purposes, all necessary documentation or corrections to support billing shall be properly completed within seven (7) working days. Therefore, for billing purposes, corrections must be made within this prescribed timeframe.

See Attachment 6 – CN Grid

IN-HOME SKILL BUILDING

In-Home Skill Building provides habilitation and skill building to enable the participant to acquire and maintain skills, which support more independence. In-Home Skill Building augments the family and natural supports of the participant and consists of an array of services that are required to maintain and assist the participant to live in community settings.

In-Home Skill Building consists of:

- Training in interpersonal skills and development and maintenance of personal relationships
- Skill building to support the participant in increasing community living skills, such as shopping, recreation, personal banking, grocery shopping and other community activities
- Training with therapeutic exercises, supervision of self-administration of medication and other services essential to healthcare at home, including transferring, ambulation and use of special mobility devices
- Transportation to support implementation of in-home skill building

In-Home Skill Building is provided when a primary caregiver is home or when that primary caregiver is regularly scheduled to be absent. In-Home Skill Building is individualized, specific, and consistent with the participant's assessed disability specific needs and is not provided in excess of those needs. In-Home Skill Building is furnished in a manner not primarily intended for the convenience of the participant, primary caregiver, the provider, employer of record or the managing employer.

This service is distinctive from personal care by the presence of training. The mixture of in-home skill building and personal care must be specified in the Individual Support Plan. It is anticipated that the presence of In-Home Skill Building will result in a gradual reduction in hours as the participant is trained to take on additional tasks and masters skills (fading plan). A formal fading plan is not required.

These services are provided in the participant's private home and not in the home of the direct service employee. In-Home Skill Building Services must start and/or end at the home of the participant.

EXCLUSIONS:

- This service is not provided to participants who receive Residential Supports.
- This service may not be furnished / billed at the same time of day as Day Supports, Community Networking, In-Home Intensive Supports, Personal Care Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person.
- For participants who are eligible for educational services under the Individuals With Disability Educational Act, In-Home Skill Building does not include transportation to/from school settings. This includes transportation to/from the participant's home or any other community location where the participant may be receiving services before or after school.

LIMITS ON DURATION, AMOUNT OR FREQUENCY

The amount of In Home Skill Building is subject to the Limits on Sets of Services specified in *Appendix M. The amount of In Home Skill Building also is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.

SERVICE DELIVERY METHOD

Provider Directed and Approved as a provider in the PIHP provider network – MCH is the provider agency.

Agency staff that work with participants:

- Are at least 18 years of age
- If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance (Bodily injury $100,000 each person and $300,000 each accident).
- Criminal background check present no health and safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in CPR and First Aid
- Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP
- High school diploma or high school equivalency (GED)
- Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012
- Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies.
- Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The participant, however, may select any enrolled Crisis Services provider in lieu of this provider.
- The organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP.
- For participants who are eligible for educational services under the Individuals With Disability Educational Act, In-Home Skill Building does not include transportation to/from school settings. This includes transportation to/from the participant's home, provider home where the participant may be receiving services before or after school or any other community location where the participant may be receiving services before or after school. Transportation between the participant's home and the provider's home is not billable service time.
- In-Home Skill Building cannot be billed during official school hours. This does not include holidays or snow days.

IN-HOME SKILL BUILDING ADMISSIONS/DISCHARGE

POLICY

1. All applicants must:
2. Be approved by the MCH Admissions Committee prior to admission.
3. Have the Innovations Waiver.
4. In Home Skill Building services serves individuals who meet the following criteria:
   a. intellectual and developmental disabilities
   b. eligible for ICF-MR level of care as documented on an **LOC** approved by a physician or clinical psychologist **and** SNAP
   c. resident of the state of NC
   d. at least **5** years of age or older
   e. approved ISP with Community Networking Services
5. Applicants are screened based on at least 3 deficits in level of care or the NC SNAP and ICF-MR level of care. The level of care should include an IDD diagnosis. Other evaluations such as psychological and intelligence tests may also be used in screening.
6. In order to be meet LOC, the applicant is screened to determine if he/she meets the following criteria:

7. have a diagnosis of intellectual and developmental disabilities (per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition, Intelligence Quotient (IQ) test results indicating intellectual and developmental disabilities, **or**
8. a condition that is closely related to intellectual and developmental disabilities. Intellectual and developmental disabilities is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability must manifest before age 22. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets **ALL** of the following conditions: a. is attributable to cerebral palsy, epilepsy; **or a**ny other condition, other than mental illness, found to be closely related to intellectual and developmental disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. The related condition manifested before age 22 and is likely to continue indefinitely and have intellectual and developmental disabilities or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas (1) self-care (ability to take care of basic life needs for food, hygiene, and appearance), (2) understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally), (3) learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations). (4) mobility (ambulatory, semi-ambulatory, non-ambulatory), (5) self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life), (6) capacity for independent living (age-appropriate ability to live without extraordinary assistance). Reports by physicians, psychologists, and other appropriate disciplines are evaluated to determine whether an individual has a substantial functional limitation in a major life activity.
9. In Home Skill Building Services under North Carolina State Medicaid Plan differs in service definition and provider type from the services offered under the waiver. In Home Skill Building Services under the waiver provides habilitation and skill building to enable the person served to acquire and maintain skills which support more independence.
10. In Home Skill Building services is provided when the primary caregiver is home or when the primary caregiver is regularly scheduled to be absent. In Home Skill Building Services must start or end at the home of the person served.
11. There shall be no discrimination with regard to race, color, sex, religion, national origin, or political affiliation in considering placement. MCH complies with the Title VI (Civil Rights, 1964), Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.)
12. The applicant must be able to have needs met by MCH and must be able to participate in or more of the essential services in the definition. The client and/or legally responsible persons must agree to abide by the rules and regulations of the service definition.
13. The Admissions Committee shall consist of the following members:
14. Executive director
15. Program director
16. QP
17. RN
18. Care Coordinator
19. The Admissions Committee shall review all admissions.

DISCHARGE

POLICY

1. The discharge committee is made up of the same representatives as the admissions committee and shall have final determination when a client is discharged. Other consultants such as the psychologist, physical therapist, etc. may be included in the decision.
2. No client shall be discharged without a recommendation from the executive director, program director, and admissions/discharge committee.

3. Normally, the only the only reason for discharge would be the inability to meet the health and welfare of the Innovations recipient or noncompliance of a family/guardian.
4. In addition, MCH is responsible for letting the MCO know of an impending discharge and reasons for discharge.
5. The client or legally responsible person shall receive a copy of the discharge plan.
6. A client may be discharged if the client and/or family make a request for discharge.
7. Unless in the event of an emergency, the client or legal guardian(s) must receive 60 days' notice.

IN-HOME SKILL BUILDING DOCUMENTATION

POLICY

The minimum service documentation requirements for services provided through the NC Innovations Waiver are contained in this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2. Information concerning documentation of all Medicaid or State funded services not contained in the NC Innovations Waiver can also be found in the Records Management and Documentation Manual 45-2.

Services must be documented by all Medicaid providers and done so prior to seeking Medicaid payment. There shall be follow-up documentation to reflect attempts to ascertain why a participant is not participating in a service/support in accordance with the established schedule or plan.

SERVICE NOTE

For Service Note requirements please refer to the Records Management and Documentation Manual (chapter 8 & 9) The following NC Innovation services require a full service note, which includes Items 1 through 13, under Contents of a Service Note, Chapter 8 of the Records Management and Documentation Manual.

A service grid shall be completed daily or per activity to reflect the service provided.

All entries in the service record shall be signed with a full signature. A full signature is to include the credentials, degree or licensure for professional staff or the position of the individual who provided the service for paraprofessional staff. Please refer to the Records Management and Documentation Manual 45-2 (Chapter 9) for signature requirements.

FREQUENCY OF SERVICE DOCUMENTATION

All NC Innovations services require a daily or per activity service note or grid. The person who provided the service shall write and sign the service note or grid. The service note or grid to reflect services provided shall be documented on the day that the service was provided or no later than the next workday. If a service note or grid is not documented on the day the service was provided, it shall be considered a "late entry."

Late entries are defined as those which are entered after the required time for documentation has expired. The entry shall be noted as a "late entry" and at a minimum the date the documentation was made and the date for which the documentation should have been documented. For example, "Late Entry made on 2/15/12 for 2/14/12." The late entry must include a dated signature. Service notes shall be made at the frequency necessary to indicate significant changes in the participant's status, needs or changes in the Individual Support Plan.

CORRECTIONS IN THE SERVICE RECORD

Changes or modifications in the original documentation for the purpose of making a correction can be made at any time, when appropriate. Whenever corrections are necessary in the participant's record, service providers should refer to the procedures as noted in the Records Management and

Documentation Manual 45-2 (Chapter 9). However, for quality assurance and reimbursement purposes, all necessary documentation or corrections to support billing shall be properly completed within seven (7) working days. Therefore, for billing purposes, corrections must be made within this prescribed timeframe.

See Attachment 7 – IHSB Grid

RESPITE SERVICES

Respite services provide periodic support and relief to the primary caregiver(s) from the responsibility and stress of caring for the beneficiary. This service enables the primary caregiver to meet or participate in planned or emergency events, and to have planned time for him/her and/or family members. Respite may be utilized during school hours for sickness or injury. Respite may include in and out-of-home services, inclusive of overnight, weekend care, or emergency care (family emergency based, not to include out of home crisis). The primary caregiver is the person principally responsible for the care and supervision of beneficiary and must maintain his/her primary residence at the same address as the beneficiary.

EXCLUSIONS:

- Respite services may not be used as a daily service in individual support.
- Respite is not available to beneficiaries who receive Residential Supports and/or those who live in licensed residential settings or AFL homes.
- Staff sleep time is NOT reimbursable.
- Respite services are only provided for the beneficiary; other family members such as siblings of the beneficiary, may not receive care from the provider while Respite Care is being provided/billed for the beneficiary
- Respite is not provided by any beneficiary who resides in the beneficiary's primary place of residence.
- For beneficiaries who are eligible for educational services under Individual's With Disability Educational Act, Respite does not include transportation to/from school settings. This includes transportation to/from beneficiary's home, provider home where the beneficiary may be receiving services before or after school.
- Respite may not be used for beneficiaries who are living alone or with a roommate.
- Respite is NOT available the same time of day as Community Networking, Day Supports, In-Home Skill Building, Personal Care, Supported Employment or one of the State Plan Medicaid services that works directly with the person such a Private Duty Nursing.

LIMITS ON AMOUNT, FREQUENCY OR DURATION

The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-IID Facility. The amount of Respite Services is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.

SERVICE DELIVERY METHOD

Provider Directed and Approved as a provider in the PIHP provider network-MCH is the provider agency.
Agency staff will that will work with participants:

- Are at least 18 years of age
- If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and ha an acceptable level of automobile liability insurance (Bodily injury $100,000 each person and $300,000 each accident).
- Criminal background check present no health and safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in CPR and First Aid
- Qualified in the customized needs of the participant described in the ISP
- High school diploma or high school equivalency (GED)

- Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10ANCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- Associate professionals providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012.
- Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to participant situations. The individual, however may select any enrolled Crisis Services provider in lieu of this provider.
- Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least 1 of designated accreditation agencies.
- The organization must be established as a legally constituted entity capable of meeting all the requirements of PIHP.
- Services provided in the private home of the direct service employee are subject to the PIHP Health and Safety assurances checklist and monthly monitoring by the Employer of Record or provider agency Qualified Professional.

RESPITE ADMISSIONS/DISCHARGE

POLICY

1. All applicants must:
   a. Be approved by the MCH Admissions Committee prior to admission.
   b. Have the Innovations Waiver.
2. Respite serves individuals who meet the following criteria:
   a. intellectual and developmental disabilities
   b. eligible for ICF-IID level of care as documented on an **LOC** approved by a physician or clinical psychologist and SNAP
   c. resident of the state of NC
   d. at least **5** years of age or older
   e. approved ISP with Personal Care Services
3. Applicants are screened based on at least 3 deficits in level of care or the NC SNAP and ICF-IID level of care. The level of care should include an IDD diagnosis. Other evaluations such as psychological and intelligence tests may also be used in screening.
4. In order to be meet LOC, the applicant is screened to determine if he/she meets the following criteria:
   a. have a diagnosis of intellectual and developmental disabilities (per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition, Intelligence Quotient (IQ) test results indicating intellectual and developmental disabilities, **or**
   b. a condition that is closely related to intellectual and developmental disabilities. Intellectual and developmental disabilities is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability must manifest before age 22. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets **ALL** of the following conditions: a. is attributable to cerebral palsy, epilepsy; **or a**ny other condition, other than mental illness, found to be closely related to intellectual and developmental disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. The related condition manifested before age 22 and is likely to continue indefinitely and have intellectual and developmental disabilities or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas (1) self-care (ability to take care of basic life needs for food, hygiene, and appearance), (2) understanding and use of language (ability to both understand others and to express ideas or information to others either

verbally or non-verbally), (3) learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations). (4) mobility (ambulatory, semi-ambulatory, non-ambulatory), (5) self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life), (6) capacity for independent living (age-appropriate ability to live without extraordinary assistance). Reports by physicians, psychologists, and other appropriate disciplines are evaluated to determine whether an individual has a substantial functional limitation in a major life activity.

c. Respite under North Carolina State Medicaid Plan differs in service definition and provider type from the services offered under the waiver. Personal Care Services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging the participant describes the flexibility of activities that may encourage the participant to maintain skills gained during habilitation while also providing supervision for independent activities. *This service may include preparation of meals, but does not include the cost of the meals themselves.*
   When specified in the ISP, this service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the participant, rather than the participant's family. Personal care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation, and use of special mobility devices.
d. Respite may be provided outside of the private home as long as the outcomes are consistent with the support described in the ISP. Services may be allowed in the private home of the provider, staff or an Employer of Record, or staff of an Agency With Choice if there is documentation in the ISP that the participant's needs cannot be met in the participant's private home or another community location. MCH does not allow Personal Care in staff homes.

5. There shall be no discrimination with regard to race, color, sex, religion, national origin, or political affiliation in considering placement. MCH complies with the Title VI (Civil Rights, 1964), Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.)
6. The applicant must be able to have needs met by MCH and must be able to participate in or more of the essential services in the definition. The client and/or legally responsible persons must agree to abide by the rules and regulations of the service definition.
7. The Admissions Committee shall consist of the following members:
   (a) Executive director
   (b) Program director
   (c) QP
   (d) RN
   (e) Care Coordinator
8. The Admissions Committee shall review all admissions.

DISCHARGE

POLICY

1. The discharge committee is made up of the same representatives as the admissions committee and shall have final determination when a client is discharged. Other consultants such as the psychologist, physical therapist, etc. may be included in the decision.
2. No client shall be discharged without a recommendation from the executive director, program director, and admissions/discharge committee.
3. Normally, the only the only reason for discharge would be the inability to meet the health and welfare of the Innovations recipient or noncompliance of a family/guardian.
4. In addition, MCH is responsible for letting the MCO know of an impending discharge and reasons for discharge.
5. The client or legally responsible person shall receive a copy of the discharge plan.
6. A client may be discharged if the client and/or family make a request for discharge.
7. Unless in the event of an emergency, the client or legal guardian(s) must receive 60 days' notice.

RESPITE DOCUMENTATION

POLICY

The minimum service documentation requirements for services provided through the NC Innovations Waiver are contained in this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2. Information concerning documentation of all Medicaid or State funded services not contained in the NC Innovations Waiver can also be found in the Records Management and documentation Manual 45-2.

Services must be documented by all Medicaid providers and done so prior to seeking Medicaid payment. There shall be follow-up documentation to reflect attempts to ascertain why a participant is not participating in a service/support in accordance with the established schedule or plan.

SERVICE NOTE

For Service Note requirements please refer to the Records Management and Documentation Manual (chapter 8 & 9) The following NC Innovation services require a full service note, which includes Items 1 through 13, under Contents of a Service Note, Chapter 8 of the Records Management and Documentation Manual.

A service grid shall be completed daily or per activity to reflect the service provided.

All entries in the service record shall be signed with a full signature. A full signature is to include the credentials, degree or licensure for professional staff or the position of the individual who provided the service for paraprofessional staff. Please refer to the Records Management and Documentation Manual 45-2 (Chapter 9) for signature requirements.

FREQUENCY OF SERVICE DOCUMENTATION

All NC Innovations services require a daily or per activity service note or grid. The person who provided the service shall write and sign the service note or grid. The service note or grid to reflect services provided shall be documented on the day that the service was provided or no later than the next workday. If a service note or grid is not documented on the day the service was provided, it shall be considered a "late entry."

Late entries are defined as those which are entered after the required time for documentation has expired. The entry shall be noted as a "late entry" and at a minimum the date the documentation was made and the date for which the documentation should have been documented. For example, "Late Entry made on 2/15/12 for 2/14/12." The late entry must include a dated signature. Service notes shall be made at the frequency necessary to indicate significant changes in the participant's status, needs or changes in the Individual Support Plan.

CORRECTIONS IN THE SERVICE RECORD

Changes or modifications in the original documentation for the purpose of making a correction can be made at any time, when appropriate. Whenever corrections are necessary in the participant's record, service providers should refer to the procedures as noted in the Records Management and Documentation Manual 45-2 (Chapter 9). However, for quality assurance and reimbursement purposes, all necessary documentation or corrections to support billing shall be properly completed within seven (7) working days. Therefore, for billing purposes, corrections must be made within this prescribed timeframe.

See Attachment 8 - Respite Grid