TITLE 473
SOCIAL SERVICES FOR AGED AND DISABLED ADULTS

CHAPTER 1-000 ADMINISTRATION

1-001 Legal Basis

1-001.01 Federal Law: Each state designs its own Social Services Program to meet the needs of its population. This title describes the adult services program established by the Nebraska Department of Social Services (NDSS) to provide and coordinate services to aged and disabled people.

1-001.02 State Statute: Article 12, Reissue Revised Statutes of Nebraska, 1943. Section 68-1202 states, "Social Services may be provided on behalf of recipients with payments for such social services made directly to vendors" and lists mandatory and optional services to clients.

Section 68-703, R.R.S., 1943, lists the duties of the Director of NDSS, including the power to, "establish rules and regulations for efficiently administering the department and performing the duties assigned to it." According to Section 68-1204, the Director of the Department of Social Services "may promulgate rules and regulations, enter into agreements, and adopt fee schedules with regard to social services described in Section 68-1202."

1-002 Agency Organization: The Social Services Program is a statewide operation.

1-002.01 Central Office: Central Office staff are responsible for service program management, development, and accountability and fiscal control.

1-002.02 Local Offices: Local staff ensure that federal and state regulations are upheld, that clients' rights are protected, and that clients' needs are served. A determination of eligibility for applicants who do not meet the requirements outlined in this title is misappropriation of public funds. Local responsibilities are divided into the following areas.

1-002.02A Case Management: Local staff responsible for case management act as the central control of each client's case. It is their responsibility to -

1. Assess client needs;
2. Determine client eligibility;

3. Arrange and authorize provision of appropriate services, using an approved provider;
4. Periodically review the service plan; and
5. Provide information and referral.

1-002.02B Resource Development: Local staff assigned resource development duties are responsible for the following:

1. Resource recruitment;
2. Provider approvals and contracts;
3. Staff development and training;
4. Provider training; and
5. Public relations and public information activities.

1-002.02C Service Administration: Administrative staff are responsible to -

1. Review and edit social services documents;
2. Review and analyze reports;
3. Complete necessary accounting and research reports;
4. Provide analysis of statistical data; and
5. Consider clients' needs, mandated policies, and administrative dictates in determining -
   a. Staffing needs;
   b. Training needs;
   c. Facilities;
   d. Intra-agency policies and procedures;
   e. Budgeting;
   f. Data support; and
   g. Client processing.

1-003 Definitions

Adverse Action: A determination by the worker that the service(s) provided to a client will be reduced or terminated.

Department: the Department of Health and Human Services (DHHS) as established by the Health and Human Services Act.

Department Staff: Employees of the Department of Health and Human Services or designees assigned those responsibilities.

Emancipated Minor: A child age 18 or younger is considered emancipated if s/he has -

1. Married; or
2. Moved away from the parent's home and is self-supporting.

Follow Up: The maintenance of any necessary contact with a client to monitor the continued appropriateness of service.

Legally Responsible Individual: A parent or guardian of a minor child, or spouse.

Prudent Person: The practice of assessing all circumstances regarding case eligibility and using good judgment in requiring further verification or information before determining initial or continuing eligibility.

1-004 Service Client Appeal: Every service applicant or client has the right to appeal for a fair hearing in relation to the following:

1. Determination that the applicant is not eligible to receive social services;
2. Denial of service;
3. Termination or reduction of service; or
4. Inaction or improper actions of the local service unit.

Exception: A client is not entitled to a fair hearing when either state or federal law requires automatic case adjustments for classes of clients unless the reason for an individual appeal is incorrect eligibility determination.

1-004.01 Local Unit Responsibilities Regarding Appeals: The local unit shall -

1. Inform each applicant of his/her right to file an appeal with the Director;
2. Inform the applicant/client of the method for filing an appeal;
3. Inform the applicant/client that s/he may designate an authorized representative or that s/he may represent himself/herself at the hearing;
4. Inform the client that service will continue unchanged until a hearing decision is made if a fair hearing is requested in writing within ten days of the date Form "Client's Notice of Action," was mailed (see 473 NAC 2-006.03D); and
5. Refer to ~~I~~465 NAC for instructions on appeals procedures.

1-005 Summary of Forms: Instructions for forms are contained in the appendix to this title:

Form Title	Appendix Reference
Social Service Exception	473-000-21
Social Services Application	473-000-22
Physician's Disability Determination	473-000-23
Client's Notice of Action	473-000-29
Adult Abuse/Neglect Report	473-000-39
Chore Service Provider Check List	473-000-50
Adult Day Service Provider Check List	473-000-60
Adult Family Home Application	473-000-70
Adult Family Home Sponsor Medical Report	473-000-71
Adult Family Home Agreement	473-000-72
Adult Family Home Inspection Referral	473-000-73
Evaluation of Adult Family Home	473-000-74
Adult Family Home Certificate	473-000-75
Home Delivered or Congregate Meals Provider Check List	473-000-90
Abuse/Neglect Hotline Intake Form	473-000-120
Employer Appointment of Agent (Form IRS-2678)	473-000-140

1-006 Title Organization: Title 473, "Social Services for Aged and Disabled Adults," is divided as follows:

1. Chapter 1-000, "Administration";
2. Chapter 2-000, "Application and Eligibility";
3. Chapter 3-000, "Social Services Providers";
4. Chapter 4-000, Reserved;
5. Chapter 5-000, "Defined Services";
   a. Chore Service (Section 5-001);
   b. Adult Day Services (Section 5-002);
   c. Alternate Care Service (Section 5-007);
   d. Home Delivered and Congregate Meals Service (Section 5-010);
   e. Homemaker Service for Adults (Section 5-011);
   f. Adult Protective Services (Section 5-015);
   g. Transportation Services for Adults (Section 5-018); and
   h. Special Services for Mentally Retarded Persons (Section 5-019);
6. Chapter 6-000, "Supportive Services" -
   a. Adult Family Homes (Section 6-001); and
   b. Reporting Unlicensed Facilities and Homes (Section 6-002); and
7. Chapter 7-000 “Adult Protective Services”.

CHAPTER 2-000 APPLICATION AND ELIGIBILITY

2-001 Requests: Any person may contact the agency by telephone, in writing, or in person to obtain information, explore eligibility, or to make arrangements to apply for services for himself/herself or as a representative of another person.

2-001.01 Response to Requests: Staff must accept requests at the DHHS office or at other places in the community. Each office must establish a method of recording requests.

2-001.02 Request Time Limits: Staff must take action to secure an application as soon as possible. If the client does not keep appointments or cannot be contacted within 30 days of the request, the worker must document the circumstances and file the request.

2-001.03 Interview: An interview is required at initial eligibility determination. The agency will conduct a face-to-face interview if requested by the client, or determined necessary by the agency using the prudent person principle (see 473 NAC 1-003). If a client, for good reason, is unable to conduct a face-to-face interview in the DHHS office, then the worker and the client must identify a mutually acceptable time and place, such as a hospital, senior or community center, or the client's home.

The worker must hold the interview with:

1. A prospective adult client;
2. The client's legal guardian or conservator; or
3. An adult representing the client.

2-001.04 Application: An individual or his/her representative must complete an application Form MILTC-3A, "Social Service Application," or Form EA-117, "Application for Assistance," which are incorporated in the appendix of these rules. The application may be submitted in person, by mail, by fax, or by electronic submission. If requested, the worker must assist the applicant or representative in completing the application. The worker must take action on the application within 30 days of the date the application is signed. Form HHS-6, "Client's Notice of Action," must be used to inform the applicant of the action.

2-001.04A Right to Apply: Any person residing in Nebraska has the right to apply for social services.

2-001.04B Family Size: Family size is defined as a unit consisting of one or more adults (individuals at least age 19 or age 18 for Adult Protective Services) and children, if any, related by blood, marriage, or adoption who reside in the same household. (An unborn child may be included in the unit size if proof of pregnancy is obtained.) The following are not considered in the family size for adult services:

1. Related adults other than spouses and unrelated adults who reside together;
2. Children living with non-legally responsible relatives;
3. Emancipated minors; and
4. A minor parent.

2-001.04C Social Security Number: If the applicant does not have a Social Security number, the worker shall call Central Office to request an interim number for use until a permanent number is obtained.

2-002 Income Eligibility

2-002.01 Categories of Eligibility for Adults

2-001.01A Current SSI and/or State Supplemental: Those individuals who currently receive assistance through the Title XVI Supplemental Security Income Program (SSI), the SSI Extended Benefits Program, and/or the Nebraska State Supplemental Program are eligible as current aged (CA); current blind (CB); or current disabled (CD). Recipients of Medicaid only are not eligible under this category.

2-002.01B Low Income

2-002.01B1 Low Income Aged (LA): An individual age 60 or older whose family income is within income guidelines is eligible as LA. (See 473 NAC 2-002.02.)

2-002.01B2 Low Income Blind (LB): An individual age 19 through 59 who has a visual impairment, who meets the definition for low income disabled and whose family income is within income guidelines is eligible as LB.

2-002.01B3 Low Income Disabled (LD): An individual eligible as LD must have a family income which is within income guidelines (see 473 NAC 2-002.02) and a physical or mental impairment which substantially prevents him/her from engaging in useful occupations within his/ her competence, such as holding a job or homemaking. This impairment must be verifiable by medical findings of -

1. Physical impairment: Loss or defects of the extremities, malfunctioning of the organs of the body or physiological disturbances with structural damage; and/or
2. Mental impairment: Conditions characterized by a marked and consistent failure to adjust to the emotional, social, or individual demands of living which require that the individual have assistance in essential activities of daily living.

2-002.01C Without Regard to Income (WI): An individual who is not eligible as a current recipient or as low income but requires the authorization of Adult Protective Services is eligible without regard to income on a time-limited basis. (See 473 NAC 7-000.)

2-002.02 Action on Income Declaration: If Form DSS-3A shows receipt of public assistance income or income not exceeding the maximum, the worker shall conduct a needs assessment (see 473 NAC 2-004) and -

1. Complete Part VI of Form DSS-3A noting the client's eligibility classification;
2. Notify the client of his/her eligibility (see 473 NAC 2-006.03); and
3. Develop a service plan. Provision of service may begin immediately.

2-002.03 Maximum Allowable Income: For clients to be determined eligible as LA, LB, or LD, their income must not exceed the maximum allowable monthly income (see Appendix 473-000-210). The current base level income is $682 gross per month for an individual or $764 for a family of two or more. Cost of Living Adjustment (COLA) to the base level income is calculated each fall when the new COLA amount is released by the Social Security Administration (see Appendix 473-000-210). If the applicant's income is verified on Form DSS-3A as equal to or less than this amount, s/he is income-eligible for the various services outlined in this title.

2-002.03A Sources of Income: When determining eligibility, the worker shall consider the following sources of income:

1. Aid to Dependent Children (ADC);
2. Supplemental Security Income (SSI);
3. State Supplemental Payment;
4. Gross wages/salary - total money earnings received for work as an employee, including wages, salary, armed forces pay, earnings through a work incentive program, vocational rehabilitation incentive pay, commissions, tips, piece rate payments, and cash bonuses earned before deductions are made for taxes, bonds, pensions, union dues, and similar purposes;
5. Work study for a graduate student or a student working for a second degree;
6. In-kind income received in lieu of wages;
7. Income received under a Job Training Partnership Act Program;
8. Social Security or Railroad Retirement - pensions, survivor's benefits, and permanent disability insurance payments made by the Social Security Administration or Railroad Retirement Board (consider amount before deductions for medical insurance);
9. Dividends - includes dividends from stockholdings or membership in associations;
10. Interest - on savings or bonds, averaged over the period earned;
11. Estates;
12. Trust funds;
13. Rentals - net income from rental of a house, store, or other property;
14. Land lease income;

15. Boarders - gross payments from boarders or lodgers (if self-employed, see item 30);
16. Royalties - net royalties;
17. Retirement pensions - retirement or pension benefits paid to a retired person or his/her survivors by a former employer or by a union, either directly or through an insurance company;
18. Veteran's pensions - money paid by the Veteran's Administration to disabled members of the armed forces or to survivors of deceased veterans, subsistence allowances paid to veterans for education and on-the-job training, and "refunds" paid to ex-servicemen as G.I. insurance premiums;
19. Military allotments;
20. Picket or strike pay;
21. Contributions;
22. Lump sum payments, e.g., child suport or Social Security (contact Central Office for assistance in considering unusual lump sum payments);
23. Annuities - annuities or insurance;
24. Unemployment compensation - compensation received from government insurance agencies or private companies during periods of unemployment and any strike benefits received from union funds;
25. Workers' compensation - compensation received from private or public insurance companies for injuries incurred at work;
26. Court-ordered alimony and child support;
27. Payment by an absent parent to the client for child care, rent, or house payment;
28. All money contributed for the maintenance of a ward, including foster care payments;
29. Net income from farm self-employment - gross income minus operating expenses from the operation of a farm received by a client as an owner, renter, or sharecropper. Gross income includes the value of all products sold, government crop loans, money received from the rental of farm equipment to others, and incidental receipts from the sale of wood, sand, gravel, and similar items. Operating expenses include cost of feed, fertilizer, seed, and other farming supplies, cash wages paid to farmhands, depreciation charges, cash rent, interest on farm mortgages, farm building repairs, farm taxes (not state and federal income taxes), and similar expenses. The value of fuel, food, or other farm products used for family living is not included as part of net income; and
30. Net income from nonfarm self-employment - gross income minus expenses from one's own business, professional enterprise, or partnership. Gross income includes the value of all goods sold and services rendered. Expenses include costs of goods purchased, rent, heat, light, power, depreciation charges, wages and salaries paid, business taxes (not personal income taxes), and similar costs. The value of salable merchandise consumed by the proprietors of retail stores is not included as part of net income.

2-002.03B Income Exclusions: When determining eligibility, the worker shall not consider the following sources of income:

1. Money received from participation in the Foster Grandparent Program authorized by the ACTION Program;
2. Money awarded by the Indian Claims Commission or the Court of Claims;
3. Alaska Native Claims Settlement Act payments (to the extent that these payments are exempt from taxation under section 21(a) of the Act);
4. Money received from sale of property such as stocks, bonds, a house, or a car (unless the person was engaged in the business of selling the property in which case the net proceeds would be counted as income from self-employment);
5. Withdrawals of bank deposits;
6. Tax refunds;
7. Gifts;
8. Earned Income Credits and Advanced Earned Income Credits;
9. Lump sum inheritances or insurance payments;
10. Capital gains;
11. The value of the coupon allotment under the Food Stamp Act of 1964, as amended;
12. The value of USDA donated foods;
13. The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food service program for children under the National School Lunch Act, as amended;
14. Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
15. Earnings of a child age 18 or younger who is a full-time student or a part-time student who is not employed full-time;
    Note: Summer earnings of a child age 18 or younger are excluded if the worker verifies that the child plans to return to school in the fall.
16. Loans;
17. Any grant to a student for educational purposes;
18. Work study for an undergraduate student;
19. Home produce used for household consumption;
20. Earnings received by a youth age 18 or younger under a Job Training Partnership Act Program;
21. JTPA allowance paid for supportive services such as transportation, meals, special tools and clothing;
22. VISTA living allowances and stipends;
23. Reimbursement from the Senior Companion Program; and
24. Low Income Energy Assistance funds.
25. Housing assistance provided by Housing and Urban Development or by a local housing program;

26. Assistance received under the Disaster Relief Act of 1974 or under a federal law because of a presidentially declared major disaster;
27. Payments to a client participating in training or school attendance subsidized by the Division of Vocational Rehabilitation;
28. Payments made by Veterans Administration under the Veterans Education and Employment Assistance Act for education expenses of a veteran; and
29. Payment made by an absent parent to a child care provider, landlord, or mortgage holder on behalf of the client.

2-002.03C Deduction of Nursing Home Obligation: If the applicant/ client has been directed by the Department to pay a portion of his/her income to a nursing home on behalf of an AABD client, the worker shall deduct the amount of the obligation from the applicant's/ client's gross monthly income to determine eligibility.

2-002.03D Types of Income

2-002.03D1 Irregular Income: Irregular income is income, earned or unearned, which varies in amount from month to month or which is received at irregular intervals. This may be due to irregular employment, but even when an individual works regularly, the income may be irregular because of factors such as seasonal increases or decreases in employment and earnings (e.g., day labor or sales work on a commission basis).

The worker shall use an average of three consecutive months, if available, to project future income unless there has been a significant change.

Small, irregular earnings which are not computable or predictable are not considered.

2-002.03D2 In-Kind Income: In-kind income is any non-monetary consideration received by a client in place of income for services provided or as payment of an obligation.

2-002.03D3 Lump Sum Income: Lump sum income is money received on a one-time basis. The worker shall divide the amount of the lump sum by six months and add that figure to the gross monthly income to determine eligibility. If that amount exceeds the income maximum, the client will be considered ineligible for that six month period.

2-002.03D4 Earned Income: Earned income is money received from wages, tips, salary, commissions, self-employment, or items of need received in lieu of wages.

2-002.03D5 Unearned Income: Unearned income includes but is not limited to -

1. Social Security benefits;
2. Railroad retirement benefits;
3. Child support;
4. Unemployment compensation; and
5. Returns from savings or investments.

2-002.03D5a Treatment of Payment by Absent Parent: When an absent parent makes a payment for child care or shelter (rent or mortgage payment), whether court-ordered or through an informal arrangement, the payment is:

1. Treated as income if paid to the client; or
2. Excluded if paid to the provider.

2-002.04 Income Verification: The worker must:

1. Verify all income at the time of the initial application;
2. Verify earned income, using one month's income as a minimum, at least every 12 months;
3. Verify regular unearned income at least annually.

5. Use the prudent person principle to verify income at otherwise unscheduled times; and
6. Document all necessary income information in the client's case record.

If the client's declaration indicates eligibility, the worker may use the prudent person principle to authorize service before income verification has been received. If verification does not later substantiate eligibility, the worker shall notify the client as directed in 473 NAC 2-006.03 and terminate service provision.

If a client has weekly or bi-weekly income, the worker shall use the income conversion charts found at 473-000-203 to project monthly income.

2-002.04A Verification of Current Status: The worker shall verify current status within 30 days of the date of application shown on Form DSS-3A.

The worker may use income maintenance records to confirm current status. Offices with computer terminals may use the terminal for status confirmation. The worker may confirm current SSI status by examination of Printout SDX 260, "SDX Master File by County."

2-002.04B Verification of Low Income Status: The worker shall verify the family income shown on Form DSS-3A within 30 days of the date of application.

2-002.04B1 Use of Income Maintenance (IM) Verification: To verify any income which an applicant has already declared for public assistance and which has been verified with documented proof on file, the worker may use the existing proof of income in the applicant's IM file as sufficient documentation of income for social services verification. The worker shall indicate on Form DSS-3A that proof is contained in the IM file.

2-002.04B2 Verification of Social Security Benefits: To verify Social Security income declared on Form DSS-3A the worker shall -

1. Obtain a copy of the Social Security check from the applicant;
2. View the Social Security check without obtaining a copy and document the amount, date, and warrant number of the check;
3. Obtain verification from the Social Security Administration by initiating Social Security Form SS-1610 "Social Security -- Public Assistance Agency Information Request and Report." The Social Security Administration may require that a completed Form DPW-46, "Authorization for Investigation," accompany the request. Return of the Form SSA-1610, completed by the Social Security Administration constitutes documented verification;

4. Secure a bank statement (original or copy) listing the amount of the check, warrant number, date deposited, and identifying the source as the Social Security Administration in cases where the Social Security check is directly deposited. The case manager may obtain the bank statement from the applicant or from the bank at the applicant's request; or
5. Use any information shown on computer printouts available to the local unit.

Note: If premiums for medical insurance have been deducted from the check the worker shall add that amount to determine the client's gross benefit.

2-002.04B3 Low Income Aged: In addition to any verification necessary to determine low income status, the worker shall determine that the applicant is at least age 60 if there is reason to suspect that information provided on Form DSS-3A is incorrect.

2-002.04B4 Low Income Blind: In addition to required verifica-tion for low income status, the worker shall use the prudent person principal to confirm the applicant's visual impairment within 30 days. If the client's status is in question and verification is necessary, the worker shall obtain one of the following within 30 days:

1. Form DSS-3B, "Physician's Disability Determination" completed by a physician and confirming the individual's disability; or
2. Form SSA-1610 for adults receiving Social Security benefits due to disability. The Social Security Administration may require that a completed Form ASD-46 accompany Form SSA-1610. Completion and return of the Form SSA-1610 is confirmation. The case manager shall obtain a Form DSS-3B if s/he is unable to secure verification from the Social Security Administration within 30 days of the date of application.

Once a disability has been verified as permanent, the worker is not required to re-verify disability status.

2-002.04B5 Low Income Disabled: In addition to any verification necessary to determine low income status, the worker shall verify any disability by following the directions in 473 NAC 2-002.04B4.

FOR COMMUNITY BASED MENTAL RETARDATION (CBMR) STAFF ONLY: CBMR staff shall confirm the applicant's retardation by maintaing documentation of a medical diagnosis of mental retardation on file.

2-002.04C Verification of Without Regard to Income (WI) Status: The worker shall:

1. Determine, if possible, that the client is neither eligible as a current recipient nor willing to be determined eligible as a low income client;
2. Document the adult's need for Adult Protective Services by completing Form MILTC-60, "Adult Abuse/Neglect Report";
3. Complete only Parts I, II, and VI of Form MILTC-3A, “Social Services Block Grant Application,” (within 60 days, Part V must be signed by the client or the client's representative unless court action has been initiated; see 473 NAC 5-015.09, item 5); and
4. Authorize Adult Protective Services.

2-002.05 Burden of Proof: The worker may require the client to provide any necessary verification. All applicants shall present proof of age or family size if the worker has reason to suspect that incorrect information has been provided. If the applicant fails to provide required proof within 30 days of application, the worker shall reject the application or close the case, as appropriate.

2-003 Citizenship and Alien Status: To be eligible for social services, an individual’s status must be documented as one of the following using acceptable documents, as defined by federal regulations and listed in 473-000-603:

1. A citizen of the United States;
2. An alien lawfully admitted for permanent residence (see 473-000-604);
3. A refugee admitted to the U.S. under Section 207 of the Immigration and Nationality Act (INA);
4. An asylee under Section 208 of INA;
5. An alien whose deportation is withheld under Section 243(h) of INA;
6. An alien from Cuba or Haiti who was admitted under Section 501(e) of the Refugee Education Assistance Act of 1980;
7. A refugee who entered the U.S. before April 1, 1980, and was granted conditional entry;
8. An alien who is paroled into the U.S. under Section 212(d)(5) of INA for a period of at least one year;
9. An Amerasian immigrant under Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, as amended; or
10. An alien who has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse's or parent's family who is residing in the same household as the alien.

Receipt of SSI, SSDI, or Medicare is sufficient proof of citizenship or lawfully admitted alien status.

Individuals who declare to be U.S. citizens must be given a reasonable opportunity to present satisfactory documentation of citizenship or nationality. Benefits must not be denied, delayed, reduced, or terminated pending receipt of the requested citizenship verification. Reasonable opportunity is defined as ten days from the date documentation was requested. The worker may authorize an additional ten day extension for verification if the necessary information has been requested by the client. If DHHS has requested verification, such as an out of state birth certificate, benefits will not be denied or terminated while awaiting receipt. Once an individual has declared s/he is a U.S. citizen or national and has provided all other information to determine eligibility, benefits must be provided.

If the client is not cooperating in providing documentation, the client must be closed.

2-003.01 Verification of Alien Status: When a client states that one or more of the unit members is an alien, the worker must require the client to present verification for each alien member. If the client has documentation containing an alien registration number, the worker must verify the alien status using the Systematic Alien Verification for Entitlements (SAVE) system. For further verification procedures, see 473-000-603 and 473-000-604.

2-004 Needs Eligibility

2-004.01 Social Services Goals: Social services are authorized based on the client's income eligibility and needs and are not provided based on demand. Need for a particular service implies that the provision of that service will assist the client or his/her family members to advance toward the achievement of one of the five program goals:

1. Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
2. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
3. Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;
4. Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; or
5. Securing referral or admission for institutional care when other forms of care are not appropriate.

2-004.01A Economic Self-Support (Goal 1): Economic self-support means that a client no longer receives any public assistance (e.g., AABD, medical assistance, social services, SSI, or food stamps).

2-004.01A1 Levels: Clients assigned this goal are in various levels of achievement or maintenance of economic self-support. These levels are -

1. Reduction of assistance benefits leading to termination of these benefits; and
2. Prevention of need for benefits.

2-004.01A2 Appropriate Services: Homemaker, transportationm mental retardation services, and day care services for children.

2-004.01B Self-Sufficiency (Goal 2): All clients assigned this goal must have realistic expectations of residing in their own homes or current living arrangements while receiving only limited services. The worker shall define limited services for each case. Nursing home residents may be assigned this goal if placement in their own homes or in more independent living arrangements is feasible in the near future.

2-004.01B1 Levels: Clients assigned this goal are in various levels of goal achievement. These levels are -

1. Reduction of service dependency leading to self-sufficiency (no services); and
2. Prevention of service dependency through maintaining current service level without an increase over time.

2-004.01B2 Appropriate Services: Alternate care for adults, chore, day services for adults, home delivered or congregate meals, homemaker, transportation, and mental retardation.

2-004.01C Preventing or Remedying Neglect, Abuse, or Exploitation (Goal 3): This goal is achieved when an adult no longer requires intervention or support to ensure against neglect, abuse, or exploitation.

2-004.01C1 Levels: All clients assigned this time-limited goal are in various levels of agency involvement.

2-004.01C2 Appropriate Services: Alternate care for adults, chore, day services for adults, home delivered or congregate meals, homemaker, protective services, and transportation.

2-004.01D Preventing or Reducing Inappropriate Institutional Care (Goal 4): Clients assigned this goal are those not able to reside in their own homes independently, but who do not presently require the full time supervision and life support offered through a medical facility. The aim of all services provided under this goal is prevention of more intensive care than presently required. This goal implies that if services were not provided, the client would have to move to a more supervised or structured living arrangement. If, over a period of time, a client with Goal 4 requires increased service, the worker shall consider transfer to Goal 5.

2-004.01D1 Levels: Clients assigned this goal may be at various levels of supervision:

1. Residing in a medical facility (i.e. nursing home) with a discharge plan;
2. Residing in an adult family home;
3. Residing in a domiciliary facility;
4. Residing in a residential care facility; or
5. Residing in their own homes with a high level of social or medical services.

2-004.01D2 Appropriate Services: Alternate care for adults, chore, day services for adults, home delivered or congregate meals, homemaker, adult protective services, transportation, and mental retardation services.

2-004.01E Securing Referral or Admission for Institutional Care (Goal 5): Clients assigned this goal are expected to enter an institution within six months. An institution is any facility which provides 24-hour accommodation, board, and care.

2-004.01E1 Support Offered: Includes arranging institutional visitation or placement, counseling the client or client's representative, client advocacy, and working with the institution's intake staff.

2-004.01E2 Appropriate Services: Alternate care for adults, protective services for adults, transportation, chore, adult day services, meals, homemaker, and mental retardation services.

2-004.02 Needs Criteria: The worker shall determine that the client has no defined service need when -

1. The client is able to perform or provide for identified service needs;
2. The client has family members or caregivers who have the responsibility and/or capability to meet identified service needs;
3. The client has other relatives, friends, or interested individuals who will provide identified service needs at no cost to the client or to the service unit (see 473 NAC 2-005.04B);
4. The client has access to financial resources which may be used to meet his/her needs;
5. The client is residing in an institution (except in relation to deinstitutionalization and short-term care); or
6. The client does not meet the requirements specified for each service.

2-005 Service Plan Formulation: Selection of a goal and the approaches to its attainment are essential to planning. The worker and the client shall evaluate the approach selected and the client's potential for goal achievement. Based on this appraisal, the worker has the final authority to authorize or deny social services. The worker and client together shall develop a plan which is documented in the case record and reflected on Form DSS-4, "Case Information Summary," and Form DSS-4A, "Social Services Provider Authorization." This plan must be re- evaluated whenever necessary and at least every six months. The forms must be updated as information changes and at least annually. Before submitting Forms DSS-4 and DSS-4A, the worker shall determine whether identifying data on the client has been entered in the computer system. If the client is new to the system, the worker shall complete and submit Form PDS-100, "Client Identification Data."

2-005.01 Plan Objectives: The objectives of formulating a service plan are to -

1. Identify the client's present situation;
2. Determine if the client's present level of functioning is his/her maximum;
3. Identify conditions (barriers) which hinder maintenance or improvement in the client's present level of functioning;
4. Determine which available services, if any, will remove or overcome the barriers to maintaining or improving the present level of functioning; and
5. Develop a plan for delivery of specific services directed at removing specific barriers to enable the client to maintain or attain his/her goal.

2-005.02 Documentation

2-005.02A Narratives: Staff shall provide narrative documentation to supplement information given on Form DSS-4 and Form DSS-4A. Narratives must include -

1. Information supporting goal selection;
2. Description of barriers to goal achievement;
3. Information supporting the approach(es) selected;
4. Information supporting worker decisions and actions regarding the case;
5. Documentation of communication with the client to include notices of eligibility and denial, reduction, or termination of service;
6. Documentation of referrals to other sources; and
7. Other appropriate factual information relevant to the case.

2-005.02B Forms: Service planning and authorization is documented on Forms DSS-4, DSS-4A, and DSS-6, "Client's Notice of Action."

2-005.03 Referral: When no service plan can be formed or agreed upon, the worker shall:

1. Assess the problem and need for referral;
2. Provide information to the individual about other resources; and
3. Follow up, as appropriate.

2-005.04 Authorization: Form DSS-4A designates the vendor responsible for providing the service authorized in the plan and gives special instructions and service limitations. Each provider from whom service is purchased must receive Form DSS-4A for prior authorization of service. Data entry of Form DSS-4A is optional; if it is desired the local unit shall notify Central Office.

If an individual in-home service provider is authorized, the client shall sign Form IRS-2678, "Employer Appointment of Agent" (see 473 NAC 3-003.01).

2-005.04A Authorization Standards: To authorize any service, whether staff-provided or purchased, the worker shall -

1. Determine that the client has been found eligible on Form DSS-3A. In no case will the beginning service authorization date be prior to the beginning eligibility date shown on the application;
2. Determine that the client's need relates to one of the defined program goals and can be met within the service definition;
3. Determine that the provider is an approved vendor;
4. Identify the service on Form DSS-4;
5. Describe and authorize purchased service on Form DSS-4A before service is provided;
6. Set an authorization period which is within the eligibility period;
7. Refer to the code, maximum rate, and unit authorization policies set for each service and on each provider agreement; and
8. Explain that any authorization is subject to review to ensure that the service is delivered as authorized.

2-005.04B Authorization Termination: When a Form DSS-4A service authorization must be terminated before the end of the authorization period, the worker shall notify the affected provider in a timely manner. (Form DSS-4C may be used.)

2-006 Service Client Contacts and Notices

2-006.01 Client Responsibility to Contact: The client or representative shall contact the worker when -

1. The client's situation has changed (e.g., address, income, family composition, health);
2. The client is dissatisfied or experiencing problems with the service delivery plan; and
3. Instructed to do so by the case manager.

2-006.02 Worker Responsibility to Contact: The worker shall contact the client when -

1. There is reason to suspect that the client's eligibility has changed;
2. It is necessary to discuss the process or problems of service delivery;
3. Follow up is necessary; or
4. The service or delivery plan must be changed or terminated.

2-006.03 Notice of Agency Action: The worker shall use Form DSS-6 to provide written notification of agency action to applicants or recipients (or their representatives) when -

1. An applicant is determined ineligible for social services or a client is found ineligible at the time of verification or redetermination; and
2. A requested service is denied or provided services are to be reduced or terminated.
3. Complete any necessary checklists and approval forms; and
4. Inform the provider whether standards have been met or, if the decision has not been made, when s/he will be notified.

If the provider does not meet standards at the time of the initial visit or interview, but is willing to correct the deficiency within a reasonable period of time, the worker shall continue the application process when proof of compliance is received.

2-006.03A Advance Notice: When a provided service is to be reduced or terminated, the worker shall provide formal written notice. This notice must be dated and mailed or given to the client at least ten calendar days before the adverse action is effective.

2-006.03B Adequate Notice: If the worker has verified possible client fraud, the worker shall send a notice of termination or reduction to the client no later than the action's effective date.

2-006.03C Notice Not Required: No notice need be sent to the client in the following situations:

1. The client reports that service is no longer required and requests that his/her case be closed;
2. The worker learns of a client's death;
3. The client is committed to an institution or admitted to a nursing home on a long-term basis;
4. The client's whereabouts are unknown;
5. The worker has verified that service is being received in another county; and
6. An authorization period is ending and the client has not acted upon a request for redetermination information.

2-006.03D Service Continuation During Appeal: In cases where advance notice has been given, the client may appeal. If an appeal is requested in writing within ten days following the date Form DSS-6 was mailed, the worker shall not carry out the adverse action until a fair hearing decision is made.

In situations where only an adequate notice was required, service is not continued pending a hearing decision.

2-006.04 Client Notice of Provider Termination: When a client's provider is disapproved or is not being reapproved, the local service unit shall notify the client. A new method of service provision must be established to prevent a gap in service provision.

2-007 Social Services Exception: In specific instances, local staff may request approval from Central Office to depart from established policies to -

1. Meet extraordinary needs of individuals eligible for services; or
2. Obtain providers for eligible clients. Local staff shall request an exception by thoroughly describing specific circumstances on Form DSS-2A, "Social Service Exception." Upon receiving Form DSS-2A, Central Office staff shall make a decision on the request for exception. Central Office approval remains effective unless the situation changes or the exception is time limited.

2-007.01 Prior Approval: No local staff, client, or provider shall take action for which an exception is required/requested before the local office receives -

1. A signed and dated Form DSS-2A from Central Office which approves, or approves with modification, the requested action; or
2. Verbal approval from Central Office in emergency situations.

2-007.02 Time Guides: To ensure a timely response, local staff should send written requests for exceptions to Central Office at least ten working days before the date on which the action described in the request is to take effect.

Central Office staff shall respond as soon as possible to requests and process all requests before the requested effective date.

In emergency situations when mailing time is not sufficient, requests may be made verbally and Central Office decisions given verbally. Local staff shall describe the nature of the emergency and shall follow up on all verbal requests by submitting Form DSS-2A for case record documentation. Staff shall submit these written requests within three working days and shall include the date of the verbal request, the name of the Central Office staff member who provided the decision, and a summary of the verbal decision.

2-007.03 Maximum Allowable Units and Rates

2-007.03A Case Management: When the worker and a client determine that units of service above the maximum are needed for the client to meet his/her social services goal, the worker shall -

1. Determine how many additional units of service are needed for a specified period of time; and
2. Initiate Form DSS-2A requesting a specific number of additional units for a specific time period (e.g., per week or per month) and documenting the client's need.

2-007.03B Resource Development: When the worker assigned resource development responsibilities and a provider negotiate a rate that exceeds the maximum unit rate the worker shall -

1. Assess and document the need for the service provider;
2. Initiate Form DSS-2A requesting a specific unit rate exceeding the maximum. Include -
    a. Documented rate negotiation efforts and applicable special circumstances (e.g., provider's experience, other recruitment efforts) to justify a higher rate of reimbursement;

b. A factual comparison of the rate requested to other rates for the same service in the community. No exceptions will be granted based solely upon a statement that the rate is "usual and customary"; and
c. A summary of the provider rate history, when applicable.

Note: Once a higher rate has been approved, the worker may authorize that increase whenever the provider's contract is renewed, without submitting another Form DSS-2A.

2-007.03B1 Agency Providers: In addition, when requesting rate exceptions for agency providers, the worker shall -

1. State the agency rate in comparison to individual provider rates for the same service in the community;
2. Present the agency's plan for the initial, continued, or expanded use of the agency provider; and
3. Summarize the continued or expanded recruitment and use of individual providers of the same service.

2-007.04 Time-Limited Service Exceptions: Central Office staff shall not grant approval for extension beyond six months for the exclusive purpose of ongoing advocacy or follow up.

The following services are time-limited: Adult Protective Services, Adult Day Services, alternate care, and homemaker. When service provision requires one or more of them to continue beyond an initial six-month authorization period in order for the client to meet his/her service goal, the worker shall -

1. Develop a plan which will -
   a. Avoid increased or continued dependency on services;
   b. Assist the client to advance toward achievement of his/her program goal; and
   c. Clearly outline client and worker responsibilities in implementing the plan;
2. Document -
   a. What services have been provided during the previous six-month authorization period;
   b. What positive steps have been taken toward client goal achievement;
   c. What components of service remain to be provided through future service authorization, in order for the client to meet his/her service goal; and
   d. Other significant changes in the client's situation.
3. Determine how much service authorization extension is needed;
4. Explore other resources for service provision;
5. Document other agencies/resources working with the client; and
6. Initiate Form DSS-2A documenting need and requesting a specific number of additional units for a specific time period.

2-007.05 Service-Specific Exceptions: When requesting an exception for any of the following services, the worker must refer to the appropriate section:

1. Meals service (see 473 NAC 5-010.05);
2. Adult Protective Services (see 473 NAC 5-015.16); and
3. Transportation (see 473 NAC 5-018.05).

2-007.06 Record Maintenance: Agency staff must maintain the completed Form HHS-2A in the appropriate client or provider case file.

2-008 Assignment of Payee. Guardianship. or Conservator Status

2-008.01 Employee's Role: No employee of DHHS is allowed to serve as a guardian or conservator for any service client for whom s/he:

1. Determines eligibility;
2. Authorizes service provision;
3. Provides direct service; or
4. Has any other professional relationship which may be considered a conflict of interest.

If these conditions have been met, the client's worker must submit a request for approval to Central Office.

2-008.02 Services Worker as Protective Payee: A services worker may act as protective payee for a client only if s/he does not determine eligibility for a categorical program for that client. All other community resources must be explored before a services worker may accept the payee assignment.

2-008.03 Provider's Role: The service worker must obtain Central Office approval before a service provider who contracts with the Department may act as protective payee for a client s/he serves.

2-009 Eligibility Redetermination

2-009.01 Change in Status: The worker must complete a redetermination of eligibility when information is obtained about changes in a client's circumstances that may change his/her eligibility. The worker must complete this review as soon as possible within a 30 day time-limit.

2-009.02 Annual Redetermination: The worker must review each client's plan and needs whenever necessary. At least every 12 months, the worker must:

1. Conduct a redetermination of each client's eligibility;
2. Determine whether an interview is necessary;
3. Instruct each client to complete and sign a new Form MILTC-3A or EA-117 reflecting his/her current situation;
4. Verify information contained on the application (see 473 NAC 2-002.04); and
5. Complete necessary redetermination forms.

2-010 Case Record Maintenance

2-010.01 File Contents: Service case records must include appropriate forms for and documentation of -

1. The request for services;
2. Income verification;
3. Service eligibility; and
4. Service plan formulation (see 473 NAC 2-005.02).

2-010.02 Record Retention: Each local office shall retain the required documentation for four years from the eligibility period ending date.

2-011 Forms and Instructions: The worker shall use the following application and eligibility processing forms as necessary:

1. Form DPW-46, "Authorization for Investigation" (473-000-12);
2. Form DSS-2A, "Social Service Exception" (473-000-21);
3. Form DSS-3A, "Social Services Application" (473-000-22);
4. Form DSS-3B, "Physician's Disability Determination" (473-000-23);
5. Form DSS-4, "Case Information Summary" (473-000-25);
6. Form DSS-4A, "Social Services Provider Authorization" (473-000-26);
7. Form DSS-4C, Service Provider Notification (473-000-27);
8. Form DSS-6, "Client's Notice of Action" (473-000-29);
9. Form DSS-60, "Adult Abuse/Neglect Report" (473-000-39);
10. Form IRS-2678, "Employer Appointment of Agent" (473-000-140);
11. Form PDS-100, "Client Identification Data" (473-000-150); and
12. Form SSA-1610, "Social Security--Public Assistance Agency Information Request and Report" (473-000-170).

CHAPTER 3-000 SOCIAL SERVICES PROVIDERS

3-001 Provider Contracting Process

3-001.01 Introduction: This section contains the definitions, policies, and standards involved in evaluating and approving providers who will claim reimbursement through the social services payment system.

3-001.02 Definitions

Provider Identification Number: A nine-digit Federal Identification (FID) number or a nine-digit Social Security number (SSN) followed by a two-digit suffix code. (The two-digit suffix code is "00" unless it identifies a multiple facility.)

Service Provider Agreement: A legally binding document describing the service(s) to be provided, the agreed-upon unit(s), and the unit rate(s) for each provider. The responsibilities of the provider and of NDSS are stated in the agreement. The two types of agreements are -

1. Form DSS-8, "Agency Service Provider Agreement," the document used for providers that have one or more employees or will be subcontracting any one or part of the service(s) for which they are requesting approval; and
2. Form DSS-9, "Individual Service Provider Agreement," the document used for providers who have no employees and will not normally be subcontracting any service(s) for which they are requesting approval.

Subcontracting: Occurs when a service provider pays someone other than an employee to provide the contracted service.

Two-Digit Suffix Codes: Two identifying numbers attached to the FID number of providers who share the same FID number due to affiliation with a larger agency.

Providers assigned suffix codes are approved individually. The assigned suffix code must be used in all transactions (e.g., authorizations, billings) with and by the provider.

3-001.03 Application: A worker assigned resource development responsibilities shall conduct a face-to-face interview with each potential provider. In the application process, the worker shall -

1. Discuss and clarify each requirement the provider must meet for approval;
2. Examine the service facility, when applicable, to confirm that it meets established standards;

3. Complete any necessary checklists and approval forms; and
4. Inform the provider whether standards have been met or, if the decision has not been made, when s/he will be notified.

If the provider does not meet standards at the time of the initial visit or interview, but is willing to correct the deficiency within a reasonable period of time, the worker shall continue the application process when proof of compliance is received.

3-001.04 Conflict of Interest: No employee of DHHS or its subdivisions may be approved as a service provider if s/he is in a position to influence his/her own approval or utilization.

3-001.05 Client Relative: A relative provider may not be a legally responsible relative or legal dependent of the client.

A non-legally responsible relative of a client may be a provider if it is documented that the relative is held to the same provider requirements as non-relative providers.

3-001.06 Service Provider Agreements: The following policies govern service provider agreements:

1. Each provider must have a service provider agreement in effect before service can be authorized for purchase;
2. Resource development staff shall evaluate and approve or disapprove all service providers located within the unit's jurisdiction;
3. Service provider agreements are effective up to 12 months, are never back-dated, and must be negotiated and signed by all parties on or before the effective date;
4. Changes in service provider agreements require renegotiation of the contract. Address changes which do not affect the service location do not require a new agreement, but Form DSS-8A, "Agency Service Provider Agreement Amendment," should be completed showing the new address;
5. Notice of any change in services, units, or unit rates proposed by either the provider or the service agency must be given as soon as possible; and
6. The staff member who completes Form DSS-8 and his/her supervisor shall both sign the agency agreement.

3-001.07 Agreement Completion: When a potential provider has met all necessary requirements, the worker shall -

1. Negotiate with the provider and complete the agreement (Form DSS-8 or DSS-9); and
2. State all provider limitations on the agreements; then
3. Complete and route Form DSS-10, "Social Service Provider Identification," and
4. Notify case management staff of the agreement.

3-001.08 Multiple Facilities: There are two methods by which a provider with more than one service facility (e.g., congregate meal sites) can be evaluated and approved or disapproved. The unit(s) involved and the provider shall decide which option to use.

Multiple facilities are identified by a two-digit suffix code which the worker shall obtain from Central Office.

3-001.08A Option 1: A separate agreement (Form DSS-8) may be negotiated with each facility. This option must be used if the facilities -

1. Will bill separately; or
2. Charge different rates for the same service.

3-001.08B Option 2: One agreement (Form DSS-8) may be negotiated, listing all the facilities. If the facilities are in more than one local area, the local office where the agency's main office is located shall negotiate and sign the agreement. If the agency operates a facility in another local unit area, local staff shall evaluate the facility and forward the evaluation to the local unit which signed the agreement.

3-001.09 Provider Evaluation

3-001.09A Resource Development Responsibilities: The worker shall -

1. Hold a face-to-face evaluation interview with each potential provider at least annually;
2. Annually visit each facility in which services are provided outside of the client's home; and
3. Assess the quality of service provision at least once during the agreement period by observing service delivery, visiting the service facility, interviewing the provider, or interviewing a client served by the provider.

3-001.09B Subcontracts: Site visits are not required for subcontracted facilities. The service provider shall ensure that subcontractors meet all standards and requirements.

3-001.10 Rate Negotiation: The worker shall negotiate all terms in Section I of Forms DSS-8 and DSS-9. The rates negotiated must -

1. Be usual and customary or less for similar services in the community;
2. Not exceed amounts reasonable and necessary to ensure the quality of service;
3. Not exceed the service's maximums without prior Central Office approval. (Exception: Once Central Office has approved a rate exception, the local office may authorize that increased rate whenever the provider's contract is renewed, without submitting another Form DSS-2A); and

4. Not exceed rates charged to non-social services clients for comparable services. (Exception: The local unit may develop a mutually acceptable compromise rate with an agency which receives public funds, e.g., a meals program which accepts voluntary contributions from participants.)

The worker and the provider indicate agreement with all the negotiated terms by signing Forms DSS-8 or DSS-9.

3-001.11 Provider Contract Renewal

3-001.11A Agreement Evaluation: The worker shall use established standards to re-evaluate each service provider -

1. Before the expiration of a provider agreement; and
2. Any time there is reason to believe that the provider is not fulfilling his/her responsibilities.

Provider approval checklists and forms are required only for initial approval.

3-001.11B Worker Action: Depending on the outcome of the evaluation, the worker shall -

1. Renegotiate or terminate the provider agreement; and
2. Complete and route Form DSS-10.

3-001.12 Provider Terminations: Either the Department or the provider may terminate an agreement by giving at least 30 days advance written notice. The 30-day requirement may be waived in case of emergencies such as illness, death, injury, or fire.

3-001.12A Written Notices: The worker shall send written notice to the provider when an agreement is to be terminated by the Department. Written notice to the provider is not required if the potential provider voluntarily withdraws an application.

3-001.12B Form DSS-10: If termination or withdrawal occurs during an effective period or at the time of renegotiation, the worker shall submit Form DSS-10 marked "inactive" and show the new Thru date in Field 18.

3-001.13 Forms and Instructions: The following forms are used in the provider contracting process:

1. Form DSS-8, "Agency Service Provider Agreement" (473-000-30);
2. Form DSS-8A, "Agency Service Provider Agreement Amendment" (473-000-31);
3. Form DSS-9, "Individual Service Provider Agreement" (473-000-32); and
4. Form DSS-10, "Social Service Provider Identification" (473-000-33)

3-002 Standards

3-002.01 General Standards: The following standards apply to all service agreements:

1. The proposed service(s) must meet the Manual's service definitions and must be purchasable;
2. Staff need not contract with a potential provider if the proposed service is sufficiently available;
3. All service providers shall have a Social Security number or FID number, whichever is appropriate, before contracting;
4. The potential provider must not be the parent of the minor child receiving services nor the legal guardian, spouse, or minor child of the service client. (See 473 NAC 2-005.04B for further information regarding client relatives as providers.);
5. The provider must not have a history of chronic incorrect and/or inaccurate billings whether intentional or unintentional for services that have been provided or have a criminal history of financial mismanagement; and
6. The provider must not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult Central Registries of abuse and neglect.

If the provider is an agency, DSS staff shall review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse or neglect are in place.

If the provider is an individual, DSS staff shall check the Abuse and Neglect Central Registries to determine if any substantiated reports of abuse or neglect by the provider exist. If the provider provides services in his/her own home, DSS staff shall also check the Abuse and Neglect Central Registries to determine if any substantiated reports of abuse or neglect by household members exist. If a report of abuse or neglect has been substantiated, DSS staff shall not contract with the individual provider. If a report of abuse or neglect concerning a current SSBG provider (or household member) as perpetrator is substantiated, staff shall immediately terminate the provider contract and notify case management.

3-002.02 Provider Standards: Before furnishing any service, each provider shall sign Form DSS-9, agreeing to -

1. Provide no service to be paid through the Social Services Program before receiving authorization from the worker;
2. Provide service only as authorized, in accordance with the Department's standards as set forth in NAC Titles 473, 474, and/or 480. If providing medical transportation, NAC Title 471 also applies to Medicaid providers;
3. Submit Form DSS-5B, "Social Services Billing Document," after service is provided and within 90 days;
4. Provide service as an independent contractor. I understand and agree that I am not providing service as an employee of the State of Nebraska or of the Department;
5. Accept social services reimbursement as payment in full for each contracted services (e.g., provider will not charge clients the difference between this contract rate and private pay rate);
6. Accept a rate which is reasonable, necessary, and does not exceed the amount charged to private-paying persons;
7. Apply to social services clients the same standards applied to private-paying persons;
8. Retain financial and statistical records for four years to support and document all claims and allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20 through 74.24;
9. Permit federal, state, and local officials to monitor and evaluate the program by means such as inspecting the facility, observing service delivery, and interviewing the provider or if an emergency, the staff members;
10. Keep current any state or local license required for service provisions;
11. Respect every client's right to confidentiality and safeguard confidential information;
12. Not discriminate against any employee, applicant for employment, or social services program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90, and 41 CFR Part 60;
13. Not assign or transfer the agreement. That is, no payment for authorized services made under this agreement can go to anyone other than the service provider named in this agreement;
14. Understand and accept responsibility for the client's safety and property;
15. Continue to meet all standards pertaining to the service provided;
16. Operate a drug-free workplace;
17. Not use any federal funds received to influence agency or congressional staff; and
18. Allow Central Registry checks on himself/herself, family member if appropriate, or if an agency, agree to allow Department of Social Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place.

3-002.03 Provider Age Qualifications: A service provider must be at least 19 years old except as described in the following parts.

3-002.03A Chore Service: Minors age 13 through 18 may be approved as chore service providers if they -

1. Are acceptable to the client;
2. Provide statements from two responsible adults (not relatives) attesting to their reliability and responsibility to provide chore services, if requested by the local service unit; and
3. Meet all chore service provider standards. (See 473 NAC 5-001.08.)

3-002.03B Adult Day Services: Minors aged 16 through 18 may be approved to provide these services if they -

1. Are acceptable to the client;
2. Are capable of providing needed service, in the opinion of the worker; and
3. Meet all appropriate provider standards. (See 473 NAC 5-002.07 and 5-018.10.)

3-002.03C Respite Care Service: Minors age 16 through 18 may be approved as respite care providers if they -

1. Are acceptable to the client and caregiver;
2. Provide statements from two responsible non-relative adults attesting to their reliability and responsibility to provide respite care, if requested by the Department;
3. Are capable of providing needed supervision, in the opinion of the caregiver and the worker; and
4. Meet all appropriate provider standards (see 473 NAC 5-013.09).

Exception: Minors age 13 through 15 who meet these criterion may be authorized to provide respite care by the hour (code 1301), up to five hours per day.

3-002.03D Parental Permission: A provider under age 19 (unless s/he is an emancipated minor) shall obtain the signature of his/her parent or legal guardian on Form DSS-9.

3-002.04 Special Conditions Affecting Approval: Workers shall consult with Central Office staff before signing an agreement when the following situations arise. The potential provider's -

1. Proposed service is not clearly a defined service;
2. Proposed unit of service does not clearly coincide with one of the service unit definitions;
3. Proposed service is to be provided in excess of policy maximums;
4. Proposed unit rate exceeds the maximum rate for the service; or
5. Operation contains components which are not covered by appropriate standards.

3-003 Social Security Tax Withholding

3-003.01 Introduction: In some situations, NDSS withholds Social Security taxes (Federal Insurance Contribution Act, FICA) from provider payments. Individual in-home service providers (e.g., in-home adult day care, homemaker, and chore housekeeper) who are not self-employed are considered employees of the client for whom they provide service. NDSS, upon receiving a signed Form IRS-2678 "Employer Appointment of Agent," acts on behalf of these clients to withhold mandatory FICA taxes and pay the client's matching tax share to the IRS.

Note: The Department does not withhold federal or state income tax or federal unemployment insurance tax from any provider payment.

3-003.02 Definitions

Affected Clients/In-Home Services: The employee's share of Social Security tax is withheld from provider payments only when in-home service is provided. In-home services include only -

1. Chore service codes 0101, 0102, 0103, and 0104;
2. Adult day service codes 0201, 0202, and 0203;
3. Homemaker service codes 1102 and 1103; and
4. Respite care service codes 1301 and 1302.

Affected Providers: In-home service providers who are not affiliated with an agency and are not self-employed are subject to FICA withholding.

Earnings Taxed for Social Security: Affected providers are subject to Social Security tax payment for each calendar quarter in which they are paid $50 or more for services provided to one client. (The $50 is per client, not a total received for two or more clients.) The Department shall withhold this tax from all payments to affected providers. If a provider's earnings do not reach $50 per quarter per client, the amount withheld for that quarter is refunded.

Self-Employed Providers: Individuals who file Social Security taxes on their own behalf are considered self-employed. They are identified by a FID number rather than a Social Security number.

Social Security Tax Rates: The Department remits to the IRS an amount equal to the current Social Security tax rate for specified "in-home" services. Half of this amount is withheld from the provider as the employee's share; the other half is provided by the Department on behalf of the client employer.

3-003.03 Staff Responsibilities: Designated staff shall -

1. Ensure that each client for whom the Department will serve as agent properly completes and signs Form IRS-2678;
2. Inform the affected service providers of the Department's FICA withholding process; and
3. Indicate "subject to FICA" on Form DSS-10, if the provider is an individual (not an agency).

3-003.04 Tax Statements: By January 31 of each year, NDSS shall issue Forms 1099 and W-2, "Wage and Tax Statement," to social services providers, with copies to the IRS. Form 1099 shows the total of all non-FICA qualifying wages. Form W-2 lists FICA qualifying wages. The total annual amount paid to each provider is determined by adding the amounts shown on Forms 1099 and W-2. A provider may receive more than one Form W-2, but more than one Form-1099 per provider indicates an incorrect FID (federal identification) number.

3-003.04A W-2 Forms: Form W-2 is sent to each provider who has earned qualifying FICA wages by providing in-home services. A separate Form W-2 is provided for each client served as the client is considered the employer.

3-003.04B IRS Form 1099: One Form IRS-1099 is issued to each provider for all non-FICA qualifying wages s/he has earned as the provider is considered self-employed.

3-003.05 Form and Instructions: Form IRS-2678, "Employer Appointment of Agent," relates to withholding Social Security tax from service payments.

3-004 Volunteers

3-004.01 Orientation and Training: The local office shall ensure that volunteers used for service delivery or for administrative assistance receive general orientation and training in -

1. Basic program policies and standards;
2. Confidentiality;
3. Civil rights requirements;
4. Client right to reject service;
5. General client rights and responsibilities; and
6. Agency responsibilities.

3-004.02 Characteristics: To be effective, volunteers need to possess -

1. Maturity in dealing with and working with others;
2. A sincere desire to provide assistance to people or to agencies serving people;
3. Ample available time to give full attention and energy to volunteer duties during duty periods;
4. Sufficient skill in one or more interest areas to perform effectively;
5. Willingness to abide by and comply with agency requirements, principles, regulations, and procedures;
6. Warmth, courtesy, tolerance, and belief in the dignity of all people;
7. Willingness to accept training, supervision, and necessary reporting responsibilities;
8. Capability to function in the assigned work environment;
9. Dependability in being available at agreed-upon times;
10. Willingness to provide immediate notice of unavailability due to illness, accident, or other condition; and
11. Sufficient physical and intellectual capability to carry out assignments. (Age or educational attainment need not be considered in many assignments.)

3-004.03 Volunteer Tasks: If careful assignment is made, the local office can find appropriate assignments for volunteers with a wide range of skills. Every effort must be made to use available volunteer manpower.

Consideration should be given to using volunteers to provide -

1. Friendly visiting;
2. Tutoring;
3. Interpreting (language skills);
4. Recreational programming;
5. Telephone assurance;
6. Escort and errand service;
7. Transportation;
8. Shopping;
9. In-home service;
10. Training (functional education);
11. Distribution of materials;
12. Messenger service;
13. Consultation to welfare staff;
14. Public speaking and delivery of public awareness programs;
15. Relief to the caretaker of an aged or disabled person;
16. Child care services;
17. Forms completion and filing; and
18. Office duties.

CHAPTER 4-000 (Reserved)

CHAPTER 5-000 DEFINED SERVICES

5-001 Chore Service

5-001.01 Introduction: This section contains material which governs -

1. The authorization and provision of Chore Service; and
2. The evaluation and approval of chore service providers.

5-001.01A Chore Service Need: Chore Service is not provided based on the demand of the client. Any person receiving Social Services must have a defined need for the service in order to meet eligibility requirements.

Need implies that the provision of that service will assist the client to advance toward the achievement of program goals.

5-001.01B Chore Goals: The goals relating to Chore Service are -

1. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency (Goal 2);
2. Preventing or remedying abuse, neglect, or exploitation of adults unable to protect their own interests (Goal 3);
3. Preventing or reducing inappropriate institutional care (Goal 4); and
4. Securing referral or admission for institutional care when other forms of care are not appropriate (Goal 5).

5-001.02 Defined Chore Services: The following chore service components are those which could normally be performed by the client, but which the client is presently unable to perform as determined by the worker in the needs assessment process.

Cleaning: Light housecleaning which is required to maintain the client in a safe and sanitary environment. This includes only vacuuming, sweeping, mopping, dusting, trash removal, and cleaning and sanitation of kitchen and bathroom, cleaning and clearing refrigerator of old and spoiled foods, cleaning stove and oven as appropriate. It does not include window washing; furniture moving; cleaning closets or drawers; any exterior cleaning or maintenance; or other non-essential tasks. For essential tasks, the client shall provide necessary supplies.

Note: An exception will be considered for an APS client whose home requires major one-time cleaning.

Essential Shopping: Obtaining food, clothing, housing, or personal care items a maximum of one time per week.

Food Preparation: Preparing meals necessary and related clean-up to maintain the client's independence. The client shall provide necessary meal preparation supplies.

Full-Time/Live-In Housekeeping: Providing all chore service components, as needed.

Laundry Service: Washing, drying, folding, and storing laundry in the client's home; or utilizing laundromat services on behalf of the client using soap and machine use fees which the client provides.

Personal Care: Only bathing, dressing, shaving, and shampooing.

5-001.03 Clients Served: The worker shall authorize Chore Service only for those individuals who are age 19 or older and -

1. Current SSI or SSI State Supplemental recipients; or
2. Low income aged or disabled persons.

5-001.04 Conditions of Provision

5-001.04A Limits Based on Living Arrangements: Based upon an individual needs assessment, the worker shall authorize only the essential shopping, or medical escort components of Chore Service for individuals residing in relatives' homes, board and room homes, adult family homes, residential care facilities, or domiciliary facilities, or centers for the developmentally disabled.

5-001.04B Special Grant Circumstances: The worker shall not authorize the laundry or shopping components of Chore Service if those needs are included as a "Special Circumstance Requirement" in the AABD State Supplemental grant (469 NAC 3-004.03).

5-001.04C Personal Care: The worker shall not authorize the personal care component of Chore Service if the client is eligible for Medicaid and is receiving personal care through Home Health Services or Personal Care Aide Services. If an eligible client is not receiving service through Medicaid, the worker shall make a referral to IM.

5-001.04D Full-Time/Live-In Housekeeper: The worker shall authorize full-time housekeeper only to meet goal 4 or 5 and only when the client is living alone or when the circumstances of eligible individuals residing together indicate this need. The housekeeper may live in. Authorization of this component is not appropriate if the client's needs can be met within the unit maximums of other chore codes. A full-time housekeeper shall -

1. Provide the following components of chore service, as appropriate:
   a. Cleaning;
   b. Essential shopping;
   c. Food preparation;
   d. Laundry service;
   e. Medical escort; and
   f. Personal care;
2. Provide service to only one household;
3. Be available on a 24-hour basis to provide the authorized chore components; and
4. Bill only for the days service is actually provided.

For days the full-time/live-in housekeeper bills, payment may not be allowed for meals service or adult day service.

5-001.05 Limits for Adult Protective Service (WI)Clients: Based upon the needs assessment, the worker may authorize chore services for clients eligible without regard to income for a maximum of 31 days in situations of abuse or neglect of an individual age 18 or older under the following conditions:

1. Form DSS-60 will be filed with the State Central Registry; and
2. The client or client's representative has consented to the service by signing Part V of Form DSS-3A.

5-001.06 Maximum Rates and Allowable Units:

5-001.06A Rates: The Central Office establishes a statewide rate for chore services matching the federal minimum wage. See Appendix. Periodic increases or decreases may be made to the chore service rate in a percentage amount corresponding with legislative appropriations or budget directives from the Nebraska Legislature which result in general Medicaid service provider increases or decreases.

5-001.06B Frequency: The frequency of service is by the hour. A day rate is used for full-time live-in housekeeper.

5-001.06C Maximum Allowable Units: Department staff shall authorize up to 65 hours per month (15 hours per week) of chore services.

5-001.06D Limit Exceptions: Local units shall submit requests to exceed policy maximums to Central Office for prior approval. (See 473 NAC 2-007.) Requests to increase the number of maximum units provided will not be granted unless the request is related to an active APS case.

5-001.07 Case Management Documentation: To authorize Chore Service, the worker shall document the specific components of Chore Service to be provided and frequency of provision.

5-001.08 Chore Service Provider Standards: See 473 NAC 3-002.02 for general provider requirements.

5-001.08A Health and Safety Standards: Each chore service provider shall -

1. Be free of communicable disease, physically capable of providing service, and willing to provide a physician's verification statement, if required by the worker;
2. Have knowledge of basic first aid skills and of available emergency medical resources, if providing full-time/live-in housekeeping or personal care; and
3. Exercise reasonable caution and care in the use and storage of clients' equipment, appliances, and supplies.

5-001.08B Skill and Capability Standards: The provider shall have had training and/or home experience in carrying out chore services comparable to those which will be authorized.

5-001.08C Equipment and Supplies Standards: The chore service provider shall provide any equipment necessary to perform authorized tasks or duties, if the client does not provide them. This cost may not be authorized for service reimbursement, but may be considered in setting the provider's rate. The client shall provide household supplies.

If the authorized provider is a member of the local unit staff, any necessary equipment and supplies not otherwise available may be purchased by the local unit as an administrative expenditure.

5-001.09 Chore Form and Instructions: The first time a chore service provider is being approved, the worker shall complete Form DSS-0151, "Chore Service Provider Checklist."

5-002 Adult Day Services

5-002.01 Introduction: This section contains material governing -

1. The authorization and provision of Adult Day Services; and
2. The evaluation and approval of adult day service providers.

5-002.01A Day Services Goals: The social services goals which relate to Adult Day Services are -

1. Achieving or maintaining self-sufficiency (Goal 2);
2. Preventing or remedying neglect, abuse, or exploitation of adults (Goal 3); and
3. Preventing or reducing inappropriate institutional care (Goal 4).

5-002.02 Day Services Definitions

Adult Day Services - Home or Center: A program of structured and monitored social, manual, physical, and intellectual services/activities provided for a minimum of three hours per day. These services are provided in a supervised, ambulatory (including wheelchairs) setting - either a day services home or a center - outside an individual's own home. Adult Day Services is directed toward adults who do not require 24-hour institutional care and yet, because of physical or mental impairment (including social isolation), require services in a group setting to meet the goals identified in 473 NAC 5-002.01A.

In-Home Adult Day Services: Supervision provided for part of a day in a client's home to enable the usual caretaker (i.e., another resident of that home) to participate in employment or training. Part-time chore and homemaker activities may be included.

Adult Day Services Center: A facility which meets established standards and provides supervision and activities for four or more adults.

Adult Day Services Home: A facility which meets established standards and provides supervision and activities for less than four adults.

5-002.03 Clients Served

5-002.03A Eligibility Status: The worker shall authorize Adult Day Services only for those individuals age 19 or older who are -

1. Current SSI or State Supplemental recipients; or
2. Low income aged or disabled persons.

See 473 NAC 5-002.05 in relation to Adult Protective Services.

5-002.03B Need: Eligible clients must need Adult Day Services to increase or maintain social and emotional well-being through opportunities for intellectual, physical, manual, and social activities.

5-002.03B1: Day services activities must be necessary to -

1. Avoid unnecessary institutionalization or delay institutionalization;
2. Facilitate community readjustment after institutionalization;
3. Improve level of functioning (i.e., self-sufficiency);
4. Alleviate deteriorating effects of isolation and self-neglect; or
5. Aid in the transition from one living arrangement to another, probably more independent, living arrangement.

5-002.03B2: In assessing an individual's need for Adult Day Services the worker shall consider the following factors:

1. The individual's residential situation in terms of support available through a group or family setting;
2. What the individual has previously done with his/her time for which Adult Day Services are now being considered, or what other service arrangements existed;
3. What other supportive community resources are available to the individual which may not make the provision of Adult Day Services an urgent need; and
4. The individual's employment or training status. (Example: If the individual is employed or in a vocational or training program for part of the day, the need for Adult Day Services would be difficult to justify, as the individual would already be on the path toward goal achievement.)

5-002.03B3: In establishing an individual's need for in-home day service, the worker shall establish that -

1. The individual cannot remain alone (documentation may be requested from the individual's physician);
2. The individual's usual caretaker will be participating in employment or training;
3. The service required is of a non-medical supervisory nature (i.e., the service does not require medical skills, knowledge, training, or supervision); and
4. No other resources (e.g. volunteers or other community services) are available to meet the individual's needs.

5-002.03C Qualifications: Before authorizing Adult Day Services, the worker shall determine -

1. That the individual is not participating in a mental retardation program, a mental health day treatment program, or vocational rehabilitation services, and is unable to attend senior center activities);
2. That the individual is not confined to bed;
3. That the individual has a physician in the community; and
4. The number of hours and/or days per week required to meet the individual's needs.

5-002.04 Time Limits: The worker shall submit Form DSS-2A (see 473 NAC 2-007) to request Central Office approval before authorizing day services for four or more days per week beyond the initial six-month period.

5-002.05 Limits for Adult Protective Services (WI) Clients: Based upon the needs assessment, the worker may authorize adult day service for clients eligible without regard to income for a maximum of 31 days in situations of abuse or neglect of an individual age 18 or older under the following conditions:

1. Form DSS-60, will be filed with the State Central Register; and
2. The client or client's representative has consented to the service by signing Form DSS-3A.

5-002.06 Maximum Rates and Allowable Units:

5-002.06A Rates: Central Office establishes a statewide rate for adult day care services. See Appendix. The statewide rate is established utilizing the total federal funding appropriation to Nebraska for adult day care services and the total state funding for adult day care services divided by the projected total of the adult day care services days provided on an annual basis. The projected number of days to be provided is derived from the Department's historical data. Periodic increases or decreases may be made to the adult day care service rate in a percentage amount corresponding with legislative appropriations or budget directives from the Nebraska Legislature which result in general Medicaid service provider increases or decreases.

5-002.06B Frequency: The frequency of services is by the hour or by the day. A day is defined as six or more hours per day.

5-002.06C Maximum Allowable Units: Adult day services shall be authorized up to five days per week for the first six months. After the initial six months the worker may authorize adult day services for up to three days per week. If the client needs more days per week the worker shall request an exception from Central Office by completing the "Social Services Exception"

5-002.07 Adult Day Services Provider Standards: See 473 NAC 3-002.02, for general provider requirements.

5-002.07A Provider Skills: Personnel who provide Adult Day Services must have had training or home or work experience in performing day service duties. Personnel shall -

1. Practice courtesy, patience, and understanding with clients;
2. Be sensitive to the special needs of elderly and handicapped clients for personal attention and assistance; and
3. Be able to recognize distress or signs of illness in clients.

5-002.07B Provider Knowledge: Personnel who provide Adult Day Services shall have practical knowledge of -

1. Basic first aid procedures and available emergency medical resources;
2. Procedures to follow in case of a client's sudden illness or an accident;
3. Reasonable safety precautions to exercise when dealing with clients and their property;
4. Each client's address, telephone number, and means of transportation; and
5. Procedures to follow when problems and client grievances need to be discussed with local staff.

5-002.07C Provider Health: All personnel of adult day services facilities must be -

1. Physically capable of completing assignments; and
2. Free of communicable disease and willing to provide a physician's verifying statement, if requested by the service unit.

5-002.08 Program Standards for Centers and Homes

5-002.08A Activities

5-002.08A1 Activity Guidelines: Adult day services home and center staff shall ensure that -

1. Activities are available to all clients;
2. Each client is encouraged to participate, but free to decline;
3. The program is geared to the clients' abilities and interests;
4. The program provides intellectual and physical stimulation while preserving the dignity of the client; and
5. The program meets the financial responsibility for any activities or field trips (e.g., eating at restaurants or bowling) available as part of the Adult Day Services Program.

Chore and homemaker activities included as components of In-Home Adult Day Services must not exceed 20 percent of the provider's time in the home.

5-002.08A2 Activity Types: Adult day services home or center staff shall offer the following activities:

1. Intellectual activities for exploring subjects of interest to the client population (e.g., budgeting, art, book discussion, nutrition information, music appreciation);
2. Manual activities -- hobbies and home arts and crafts (e.g., knitting, sewing, woodworking, simple repair of home or car, cooking, gardening);
3. Physical activities which stress physical fitness, either individually or as group programs (e.g., exercises, walking, swimming, bowling, croquet); and
4. Social activities involving groups (e.g., field trips, dances, singing, shopping, games, lectures, and discussions). Adult day services staff must be present with clients at all times during the provision of any adult day service activity.

5-002.08A3 Activity Equipment: Adult day services home and center staff shall provide -

1. Furniture, equipment, supplies, and materials for clients' use (including cot(s) or recliners for rest and easy chairs);
2. Magazines, books, games, and recreational materials for clients' use; and
3. Quiet areas for reading and resting.

5-002.08B Meals: If the client is in the facility more than four hours per day and the Adult Day Services Program provides a meal, the meal must include one-third of an adult's daily nutritional requirement. If the program does not provide a meal and requires clients to bring their own food, a meals cost must be deducted from the program's daily rate of Title XX reimbursement.

5-002.08C Facilities: Adult day services home and center staff/ facilities shall -

1. Comply with fire prevention regulations, health and sanitation regulations, and zoning codes and regulations;
2. Maintain lavatory and toilet facilities that are available, accessible, and in working order;
3. Have adequate space, proper ventilation, and means of adequate temperature control for the number of clients served;
4. Maintain facilities which are safe and free from hazards and barriers; and

5. Contact the Nebraska Department of Health if -
   a. The Adult Day Services Program is to be provided in a facility licensed by that Department; or
   b. The program intends to provide medical services.

5-002.08D Records Maintenance: Adult day services staff shall maintain the following records:

1. Client charts documenting individualized adult day services goals, activities in which client's participate, and individual problem areas and progress made through service provision. (Progress notes should be recorded at least every three months);
2. Clients' physicians, pertinent medical information (e.g., activity restrictions, special diets, and medications schedules), and phone numbers of persons to contact in case of an emergency;
3. Signed consents for release of information about clients (i.e., for information-sharing with county staff regarding client needs assessments); and
4. Statistical reports containing information about -
   a. Number and source of referrals;
   b. Client attendance, services received, and method of payment;
   c. Program costs; and
   d. Program admissions and program discharges (i.e., numbers of clients and reasons for admission and discharge).

5-002.09 Adult Day Services Form and Instructions: The worker shall use Form DSS-0251, "Adult Day Service Provider Check List," for the initial evaluation and approval of adult day services providers.

5-003 through 5-006 (Reserved)

5-007 Alternate Care Service

5-007.01 Introduction: This section contains material which governs -

1. The authorization and provision of Alternate Care Service; and
2. The recruitment, evaluation, and certification of alternate living resources.

5-007.01A Alternate Care Service Goals: The goals related to Alternate Care Service are -

1. Achieving or maintaining self-sufficiency (Goal 2);
2. Preventing or remedying abuse, neglect, or exploitation of adults unable to protect their own interests (Goal 3);
3. Preventing or reducing inappropriate institutional care (Goal 4); and
4. Securing referral for institutional care (Goal 5).

5-007.01B Time Limitation: The worker shall not authorize Alternate Care Service beyond an initial six-month period unless an exception has been approved by Central Office (see 473 NAC 2-007.04).

5-007.02 Definition of Alternate Care Service: This service includes assistance in locating an alternate living arrangement (e.g. adult family home, residential care facility, or nursing home) and evaluating and assessing care provided to the client in non-institutional settings. (See IX-3620 for a description of alternate living arrangements.) The alter- nate living arrangement may be more or less restrictive than the client's present living arrangment.

5-007.03 Clients Served

5-007.03A Eligibility: The worker shall authorize Alternate Care Service only for those individuals age 19 or older who are -

1. Current SSI or State Supplemental recipients;
2. Low income aged or disabled persons; or
3. Age 18 or older and are receiving Adult Protective Service without regard to income.

5-007.03B Residents of Institutions: The worker shall not authorize Alternate Care Service for individuals residing in institutions unless in conjunction with discharge planning or de-institutionalization for the client.

5-007.04 Case Management Functions: When authorizing Alternate Care Service, the worker shall -

1. Assess the client's needs and recommend an alternate living arrangement consistent with the level of care required;

2. Review, with the client, possible resources which offer appropriate living arrangements;
3. Discuss, with the client and/or representative, the Department's responsibilities for assisting the client to locate an alternate living arrangement and for assessing that arrangement;
4. Arrange for a visit to the potential alternate living arrangement, if requested by the client;
5. If appropriate, authorize the provision of supportive services to enable the client to maintain the alternate care arrangement; and
6. Discuss the client's financial responsibility for daily living expenses. Note: Care costs and moving expenses (except for De-Institutionalization) are not covered under the Social Services Program.

5-007.05 Resource Development Functions: Staff assigned resource development responsibilities shall -

1. Maintain a current list of alternate care resources;
2. Encourage development of new or improved alternate care resources; and
3. Provide technical assistance, as appropriate.

5-007.06 De-Institutionalization

5-007.06A Introduction: De-institutionalization of a Medicaid client residing in a skilled nursing facility (SNF), intermediate care facility (ICF), or intermediate care facility for the mentally retarded (ICF/MR) is the joint responsibility of Medical Services, Income Maintenance, and, when requested, Social Services. This action is appropriate when a client's medical or social needs no longer require nursing facility care and another living arrangement is determined more appropriate.

This subsection provides staff with instructions to follow in the de-institutionalization process.

5-007.06B Definitions

County of Legal Settlement: The county financially responsible for the client's needs.

County of Residence: The county where the client physically resides.

SNF, ICF, ICF/MR: Facilities primarily engaged in providing nursing care and related services to patients requiring medical or nursing care or providing health-related care and services to individuals who, because of their mental or physical condition, are unable to live independently or in a situation where less care is provided.

5-007.06C Medical Services Functions: The state medical review team evaluates the appropriateness of each SNF, ICF, or ICF/MR client's medical and social care needs, and may, after collecting pertinent data, recommend de-institutionalization using Form DPW-100, "De-Institutionalization Referral." The recommendation must include information about the client's physical/mental condition and needs. See 471 NAC 12-008.12.

5-007.06D County of Residence Responsibilities: Each county shall assign responsibility for assisting the client to a worker in IM, in social services, or a generic worker. The worker shall arrange a move to an independent living arrangement or to a situation where less care is provided within 60 days after receiving Form DPW-100.

5-007.06D1 Meetings With the Client: Upon receiving Form DPW-100, the worker shall visit the client and/or representative, discuss the de-institutionalization recommendation, and present written notification of the recommendation. (The worker may contact the facility's discharge planner for assistance in notifying the client before this visit.) To discuss the client's needs and preferences, the worker shall arrange a meeting with the client and/or representative; his/her income maintenance or social services worker, if possible; the facility's discharge planning staff; and any interested family members.

5-007.06D2 Arranging for the Move: If the client or his representative choose to locate a living arrangement without the assistance of the worker, the worker shall advise him/her that the move must be completed within 60 days of receiving Form DPW-100 and to notify the county office when the move is completed. During the 60-day period, the worker shall contact the client or the representative to determine progress towards the client's move.

If the client or representative requests assistance, the worker shall -

1. Locate an appropriate living arrangement;
2. Discuss the arrangement with the client or representative and ensure that the arrangement is appropriate, feasible, and acceptable to the client or representative;
3. Arrange pre-placement visits, when appropriate; and
4. Arrange, when appropriate, for the transportation of the client from the facility to the new living arrangement.

The worker shall complete Form DPW-100 when the move has occurred, forward copies to the Central Office Long Term Care Unit, to Aged and Disabled Services, to the client's county of legal settlement, and retain one copy for the county file. If the move is not possible, or if more time is needed, the worker shall request assistance from the Central Office Long Term Care Unit.

5-007.06E Pre-Placement Visits: Within the 60-day period, the worker may arrange a pre-placement visit to acquaint the client with an alternate living situation. (If the visit will involve an overnight stay, see IX-6381.01). The worker shall inform the facility's administrator of the visit and discuss the purpose of the visit, length of stay, etc., with the client or representative.

5-007.06F Transportation: The worker may authorize transportation in relation to de-institutionalization only to assist the client in pre-placement visits and moving from the facility to the new living arrangement when -

1. All regulations for Transportation Service for Adults (473 NAC 5-018) have been met; and
2. The move does not involve large volume of goods and personal property (in such cases the worker should contact the IM worker for possible assistance).

5-008 and 5-009 (Reserved)

5-010 Home-Delivered and Congregate Meals Service

5-010.01 Introduction: This section contains material which governs -

1. The authorization and provision of home-delivered and congregate meals; and
2. The evaluation and approval of meal providers.

5-010.01A Meals Service Need: Meals service is not provided based on the demand of the client. Any individual receiving meals service must have a defined need for the service in order to meet eligibility requirements. Need for a service implies that the provision of that service will assist the client in achieving program goals.

5-010.01B Meals Service Goals: The goals relating to meals service are -

1. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency (Goal 2);
2. Preventing or remedying abuse, neglect, or exploitation of adults unable to protect their own interests (Goal 3);
3. Preventing or reducing inappropriate institutional care (Goal 4); and
4. Securing referral or admission for institutional care when other forms of care are not appropriate (Goal 5).

5-010.02 Meals Service Definitions

Congregate Meals: Meals prepared and served at a dining facility outside of the client's residence.

Home-Delivered Meals: Meals prepared outside of the client's residence and delivered to his/her residence. The residence must be an independent living arrangement.

Meal: A variety of properly prepared foods containing one-third of the minimum daily nutritional requirements for adults.

5-010.03 Clients Served

5-010.03A Eligibility Status: The worker shall authorize Home- Delivered or Congregate Meals Service only for those individuals age 19 or older who are -

1. Current SSI or State Supplemental recipients; or
2. Low income aged or disabled persons.

See 473 NAC 5-010.04 in relation to Adult Protective Services.

5-010.03B Need for Service: Eligible clients must -

1. Be unable to prepare adequate meals within their own residences. This inability may be due to -
   a. Physical or mental handicaps or disabilities;
   b. Chronic illness;
   c. Inability to obtain food products because of distance to the source;
   d. Lack of cooking facilities; or
   e. Lack of motivation. Lack of motivation is characterized by emotional or physical deterioration which seriously endangers the client's ability to remain in an individual living situation. Any of the following may indicate possible deterioration:
      (1) Disregards personal hygiene;
      (2) Requires another person to remind him/her to attend to basic needs;
      (3) Allows hazardous conditions to develop in the home;
      (4) Requires all meals prepared and served by others;
      (5) Requires frequent orientation as to the time, place, or date;
      (6) Refuses needed medical care;
      (7) Loss of spouse due to death or divorce in the past year;
      (8) Contact has been severed with close friends or relatives in the past year for any reason (e.g., death, divorce, moving);
      (9) Moved to a new living situation within the past year;
      (10) Discharged from a nursing home or hospital within the past year; or
      (11) A history of withdrawal from social contacts or activities;
2. Have no other person living in their homes who are able and willing to obtain, prepare, and serve adequate meals in the home; or
3. Not live in a congregate facility (e.g., board and room home or hotel) where meal service is the responsibility of the facility and the cost of meals is included in the payment rate.

The worker may authorize meals service for any of these reasons and shall periodically re-evaluate the client's need. Every effort must be made to move the client toward greater independence (e.g., providing homemaker service to teach housekeeping skills to a recent widower).

5-010.04 Limits for Adult Protective Services (WI) Clients: Based upon the needs assessment, the worker may authorize meal service for clients eligible without regard to income for a maximum of 31 days in situations of abuse or neglect of an individual age 18 or older under the following conditions:

1. Form DSS-60 will be filed with the State Central Register; and
2. The client or client's representative has consented to the service by signing Form DSS-3A.

5-010.05 Maximum Rates and Allowable Units

5-010.05A Rates: Central Office establishes a statewide rate for meal services. See Appendix. The statewide rate is established utilizing the total federal funding appropriation to the State of Nebraska for meals services and the total state funding for meals services divided by the projected total of the congregate and delivered meals to be produced on an annual basis. The projected number of meals to be produced is derived from data provided by the state Area Agency on Aging organizations. Periodic increases or decreases may be made to the meal service rate in a percentage amount corresponding with legislative appropriations or budget directives from the Nebraska Legislature which result in general Medicaid service provider increases or decreases.

5-010.05B Frequency: The frequency of service is per occurrence.

5-010.05C Maximum Allowable Units: Department staff shall authorize up to one congregate or home delivered meal per day.

5-010.06 Meals Service Exceptions: When entering into contractual agreements with meals service providers, staff shall consider the following:

1. Actual service cost in the provision of meal service is not a basis for granting a rate increase. A number of meal programs have multiple sources of funding and rate negotiation must always be explored before requesting an exception;
2. Special rates will not be granted to providers who prepare meals catering to the various dietary requirements of their clientele. Providers are required to prepare meals for special diets; and
3. No exceptions will be approved for area agencies on aging as their rates are standardized.

5-010.07 Meals Service Provider Standards: See 473 NAC 3-002.02 for general provider requirements.

5-010.08 Health and Safety Standards: Food preparation and serving facilities and areas must conform to all established local, state, or federal fire prevention, sanitation, zoning, and facility maintenance standards. Food preparation and serving personnel must be -

1. In good health and free from contagious disease;
2. Skilled and instructed in sanitary food handling, preparation, and serving practices;

3. Courteous, understanding, and helpful when seating or serving aged or handicapped clients;
4. Knowledgeable of basic first aid; and
5. Aware of available resources for medical emergencies and for transportation.

5-010.08A Home-Delivered Meal Standards: In addition to the general health and safety standards, home-delivered meals must be -

1. Delivered on an established schedule;
2. Transported in properly equipped vehicles; and
3. Transported and delivered using utensils and equipment which are sanitary and maintain proper food temperatures. Thermos-type containers and disposable or sterilizable serving dishes must be used.

5-010.08B Congregate Meal Standards: In addition to the general health and safety standards, congregate meal facilities must be -

1. Accessible to adult clients and free from architectural barriers to aged or handicapped clients; and
2. Maintained at a comfortable temperature, properly ventilated, and have sufficient space.

5-010.09 Menu and Meal Requirements: Menus for home-delivered and congregate meals must -

1. Reflect the general dietary needs of aged or handicapped people as well as the specific dietary needs of the clients served;
2. Be prepared one week in advance, entered on Form DSS-1053, "Weekly Menu Plan," (or similar form) and kept available for inspection by service unit staff at any time.
3. Contain one-third of the minimum daily nutrition requirement for adults using a variety of foods from day to day. (See Form DSS-1054, "Approved Meals Service Vendor Meals Specification List.")

5-010.10 Meals Service Forms and Instructions: The worker shall complete the following forms as required to evaluate meals service providers:

1. Form DSS-1052, "Home Delivered or Congregate Meals Provider Check List" (473-000-90);
2. Form DSS-1053, "Weekly Menu Plan" (473-000-91) (optional); and
3. DSS-1054, "Approved Meals Service Vendor Meals Specification List" (473-000-92).

5-011 Homemaker Service for Adults

5-011.01 Introduction: This section contains material which governs -

1. The authorization and provision of Homemaker Service for Adults; and
2. The evaluation and approval of homemaker providers.

5-011.01A Homemaker Need: Homemaker service is not provided based on the demand of the client. The instruction provided by the homemaker must maintain or strengthen the client's capacity to function in the most independent living situation possible.

5-011.01B Homemaker Goals: The goals relating to Homemaker Service for Adults are -

1. Achieving or maintaining economic self-support (Goal 1);
2. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency (Goal 2);
3. Preventing or remedying neglect, abuse, or exploitative of adults unable to protect their own interests (Goal 3);
4. Preventing or reducing inappropriate institutional care (Goal 4); and
5. Securing referral or admission for institutional care when other forms of care are not appropriate (Goal 5).

5-011.02 Homemaker Definitions

Homemaker Service for Adults: In-home instruction provided by a trained homemaker to aged and disabled clients. The homemaker provides service based upon the worker's evaluation of need.

Homemaker Service for Adults provides learning experiences for clients and involves the performance of tasks by a homemaker for instruction only.

Homemaker Tasks: The worker and the homemaker shall work together to identify the client's areas of inadequate functioning in -

1. Organization of household activities and time management;
2. Management, maintenance, arrangement, cleaning, and care of home appliances, equipment, eating utensils, furniture, and supplies;
3. Obtaining, storing, planning, preparing, and serving nutritious food for self or family (including any necessary special diets);
4. Management, supervision, training, and proper care of infants, children, or incapacitated family members;

5. Obtaining and properly caring for clothing, household supplies, and sundry needs of self or family (including laundry tasks of sorting, carrying, washing, drying, and ironing);
6. Maintenance of sanitation within the home;
7. Maintenance of personal hygiene and health practices for self and family members, if applicable;
8. Obtaining any necessary medical care and treatment;
9. Management and proper use of income and resources; and
10. Maintaining proper relationships and communication with family members.

5-011.03 Clients Served

5-011.03A Homemaker Eligibility Status: The worker may authorize Homemaker Service for Adults for individuals who are -

1. Current SSI or State Supplemental recipients; or
2. Low income aged or disabled persons.

See 473 NAC 5-011.03D in relation to Adult Protective Service.

5-011.03B Homemaker Need: Eligible clients must -

1. Have an identified service need (see 473 NAC 2-004.02); and
2. Be unable to maintain safe and adequate homemaking practices within their own living facilities. This inability may be caused by -
   a. A medical condition from which the client is recovering;
   b. Failure to use safe, efficient, or effective home management techniques;
   c. Lack of homemaking experience; or
   d. An unstable home life due to -
      (1) A change in living situation within the past 12 months;
      (2) Recent death of or other separation from the usual homemaker;
      (3) Adjustment to a recent handicapping condition; or
      (4) A household crisis (e.g., domestic disagreements, natural disasters).

5-011.03C Living Arrangement: Clients who live in a congregate facility are not eligible for homemaker service if the facility -

1. Is responsible to provide either homemaker service; and
2. Includes the cost of homemaker service in its rate

5-011.03D Limits for Adult Protective Service (WI) Clients: Based upon the needs assessment, the worker may authorize homemaker service for client eligible without regard to income for a maximum of 31 days in situations of abuse or neglect of an individual age 18 or older under the following conditions:

1. Form DSS-60 will be filed with the State Central Register; and
2. The client or client's representative has consented to the service by signing Form DSS-3A.

5-011.04 Maximum Rate and Allowable Units:

5-011.04A Rates: Central Office establishes a statewide rate for homemaker services matching the federal minimum wage. See Appendix. Periodic increases or decreases may be made to the homemaker service rate in a percentage amount corresponding with legislative appropriations or budget directives from the Nebraska Legislature which result in general Medicaid service provider increases or decreases.

5-011.04B Frequency: The frequency of service is by the hour.

5-011.04C Maximum Allowable Units: Department staff shall not authorize more than 65 hours per month for homemaker services.

5-011.04D Time Limit: Maximum of six months The worker shall not authorize Homemaker Services beyond an initial six-month period unless approval is received from Central Office. (See 473 NAC 2-007.04.)

5-011.05 Authorization Procedures: When authorizing homemaker service, the worker shall -

1. List specific assistance and instruction to be provided by the homemaker; and
2. Set time frames in which the client is to learn to perform each authorized homemaking task.

5-011.06 Homemaker Provider Requirements: See 473 NAC 3-002.02 for general provider requirements.
Both contracted providers and staff-provided homemakers must -

1. Have experience in performing homemaker tasks;
2. Be free of communicable disease, have the physical capability to provide service, and be willing to provide a physician's verification statement if requested by the worker;
3. Exhibit good grooming and personal hygiene practices;
4. Demonstrate acceptance of, respect for, and a positive attitude toward other people, especially those who are aged or disabled;
5. Exhibit emotional maturity in assuming responsibility, maintaining schedules, and adapting to new situations; and
6. Possess the necessary skills to -
    a. Demonstrate, complete (if necessary), and instruct individuals to adopt proper activities to overcome identified deficiencies; and

b. Observe and report all changes to the case manager.

5-011.08 Homemaker Forms and Instructions: The worker shall use the following forms as necessary in relation to Homemaker Service for Adults:

1. Form DSS-1151, "Homemaker Provider Check List" (473-000-100);
2. Form DSS-1153, "Homemaker Weekly Time Sheet" (473-000-101); and
3. Form DSS-1154, "Homemaker Service Task List" (473-000-102).

5-012 (Reserved)

5-013 Respite Care for Adults

5-013.01 Purpose: Respite Care for Adults is a service designed to provide temporary relief to the usual caregiver from the continuous support and care of a dependent aged or disabled client.

Respite care may be used to -

1. Reduce stress;
2. Reduce the social isolation of the caregiver;
3. Assist the caregiver through an emergency;
4. Reduce out-of-home placement; or
5. Increase the stability of the household.

5-013.02 Definitions

Client: An adult who requires supervision to maintain his/her present living situation.

In-Home Care: Care provided in the client's residence.

Out-of-Home Care: Care provided in a home or facility where the client does not reside.

Respite Care: Temporary care of an aged or disabled adult provided on behalf of and in the absence of the usual caregiver to allow that caregiver relief from the stresses and responsibilities of providing continued care.

Usual Caregiver: A person who resides with the client and is available on a 24-hour per day basis to assume responsibility for the care and supervision of the aged or disabled adult. This may include a caregiver who is employed outside the home if s/he retains "on-call" responsibility while away from the client.

5-013.03 Goals: The goals which relate to respite care are -

1. Preventing or remedying neglect, abuse, or exploitation of adults unable to protect their own interests (Goal 3);
2. Preventing or reducing inappropriate institutional care (Goal 4); and
3. Securing referral or admission for institutional care when other forms of care are not appropriate (Goal 5).

5-013.04 Eligibility

5-013.04A Eligibility Status: The worker may authorize respite care for individuals age 19 or older who have access to no other source of respite funding and are -

1. Current SSI or State Supplemental recipients; or
2. Low income aged or disabled persons. If determining low income eligibility for a married client, the income of his/her spouse must be included.

See 473 NAC 5-013.04C in relation to Adult Protective Services.

5-013.04B Caregiver Need: Need for this service is based upon the worker's assessment of -

1. The stress placed upon the caregiver;
2. The responsibilities the caregiver is assuming;
3. Other available non-financial resources (e.g., other relatives or community volunteers); and
4. The probable consequences to the client.

The worker shall not consider the financial circumstances of the usual caregiver, except as stated in 473 NAC 5-013.04A, item 2.

5-013.04B1 Duplicate Payments: If the caregiver is paid through another source to provide care or supervision for the client, Respite Care for Adults funds must not be used to duplicate payments.

5-013.04B1a Excluded Caregivers: The following caregivers are not eligible to receive respite service:

1. Caregivers paid for service/care provided to the client by Title XIX or Title XX;
2. Operators of facilities who are paid to provide supervision (e.g., adult family home, residential care facilities); or
3. Operators of domiciliary facilities or room and board homes. (Exception: If the client resides with a relative or friend on a room-and-board basis and that caregiver also provides supervision for the client, the caregiver may be eligible for respite care.)

Note: A facility which has an opening may wish to admit an additional client on a respite basis. As long as the facility is not being paid for the additional client through another source, the facility may contract with and bill Title XX. (Example: Mr. A is a permanent resident of a certified Adult Family Home. Mr. B lives with his adult daughter who provides his care. The AFH sponsor is not an eligible caregiver for respite from Mr. A's care, but may be the provider of respite care for Mr. B.)

5-013.04B2 Respite Situations: The worker may authorize respite service for one or more of the following situations:

1. An emergency or crisis arises which -
   a. Requires the caregiver's absence; or
   b. Places an unusual amount of stress on the caregiver;
2. The caregiver requires health services (e.g., dental care, doctor appointments, or hospitalization);
3. The caregiver needs relief for regular, pre-scheduled, personal activities (e.g., religious services, grocery shopping, or club meetings);
4. The caregiver requires irregular periods of "time out" for rest and relaxation; or
5. Caregiver vacations.

5-013.04C Limits for Adult Protective Service (WI) Clients: Based upon the needs assessment, the worker may authorize respite service for clients eligible without regard to income for a maximum of 31 days in situations of abuse or neglect of an individual age 18 or older under the following conditions:

1. Form DSS-60 will be filed with the State Central Register; and
2. The client or client's representative has consented to the service by signing From DSS-3A.

5-013.05 Budget Restrictions: Funds appropriated for Respite Care for Adults are limited. If available funds are exhausted, it will be necessary to send notices of closing or reduction in service to affected clients.

5-013.06 Maximum Rate and Allowable Units:

5-013.06A Rates: Central Office establishes a statewide rate for respite services matching the federal minimum wage. See Appendix. Periodic increases may be made to the respite service rate in a percentage amount corresponding with legislative appropriations or budget directives from the Nebraska Legislature which result in general Medicaid service provider increases or decreases.

5-013.06B Frequency: The frequency of service is by the hour or by the day. Service provided for more than 6 hours through 24 hours is equal to one day.

5-013.06C Maximum Allowable Units: The worker shall authorize in the same six- month time period no more than 120 hours per six months or 18 days per six months of respite services.

5-013.07 Respite Exceptions: The worker may request exceptions based upon special situations, rates, and/or maximum units by following the procedures in 473 NAC 2-007 et seq.

5-013.08 Department Responsibilities

5-013.08A Case Management Functions: The worker shall -

1. Identify and document the stresses and responsibilities which relate to the caregiver's capacity for providing care;
2. Assist the caregiver in locating a suitable respite care provider; and
3. Complete and submit to data entry Form DSS-4A for each respite provider.

5-013.08B Resource Development Functions: The worker shall -

1. Check the State Central Register of Abuse/Neglect. If any reports indicate a situation which may endanger the client, the Department may reject the application or revoke the provider contract;
2. Complete Form DSS-XXXX, "Respite Provider Checklist," with each provider; and
3. Consider negotiating a lower rate per client if more than one client resides in the same household.

5-013.09 Caregiver Responsibilities: The usual caregiver/client has the following responsibilities:

1. To obtain a provider who is able and willing to provide the supervision required and to accept Department payment;
2. To ensure that the provider is instructed in the proper care of the client. This includes but is not limited to -
   a. An explanation of any adaptive equipment to be used;
   b. A discussion of the client's limitations and abilities;
   c. An understanding of emergency procedures (including how to contact the caregiver and the client's doctor); and
   d. Dietary restrictions;
3. Notify the worker of any problems with service delivery.

5-013.10 Respite Provider Standards: See 473 NAC 3-002.02 for general provider requirements.

Each contracted respite provider must -

1. Meet any applicable local, state, and federal laws and regulations;
2. Be able to perform the tasks required for the client's care;
3. Accept the philosophy of care which includes acceptance of, respect for, and a positive attitude toward people who are aged or disabled;
4. Exhibit emotional maturity in assuming responsibility, maintaining schedules, and adapting to new situations;

5. Be free of communicable disease, have the physical capability to provide service, and be willing to provide a physician's verification statement, if requested by the worker;
6. Exhibit good grooming and personal hygiene practices;
7. Agree to never leave the client alone; and
8. Observe and report all changes to the caregiver and the case manager.

5-013.10A Additional Out-of-Home Standards: If respite care is to be provided outside of the client's home, the provider must also -

1. Certify that no household members or staff have been involved in a substantiated report of adult abuse/neglect;
2. Develop tornado safety and fire evacuation plans;
3. Have available an operable telephone;
4. Post emergency phone numbers by the telephone;
5. Ensure that the home/facility is accessible to the client, clean, in good repair, free from hazards, and free of rodents and insects;
6. Ensure that toilet facilities are clean and in working order;
7. Ensure that the eating areas and equipment are clean and in good repair;
8. Ensure that the home/facility is free from fire hazards;
9. Ensure that the furnace and water heater and any firearms, medications, and poisons are inaccessible to the client; and
10. Ensure that any household pets have all necessary vaccinations.

5-013.11 Forms: The first time a respite care provider is being approved, the worker shall complete Form DSS-1351, "Respite Provider Checklist."

If the client receives in-home service, Form IRS-2678, "Employer Appointment of Agent," must be completed and a copy retained in the client's file.

5-014 (Reserved)

5-018 Transportation Services

5-018.01 Introduction: Transportation service is transporting an eligible client to and from allowable community resources when the client has no other transportation. Service may be provided by an individual, exempt provider, or by common carrier.

5-018.01A Outcomes: Department staff must select one of the following outcomes to authorize transportation services:

1. Client is able to experience the optimal level of health, safety, and independence in a healthy and safe home environment.
2. Client is able to receive ongoing support from unpaid caregivers.
3. Client's risk of abuse, neglect, and/or exploitation is prevented, reduced, or eliminated.

5-018.01B Transportation Definitions:

Common Carrier means any person who transports passengers by motor vehicle for hire and is licensed as such with the Public Service Commission (PSC).

Department means the Department of Health and Human Services (DHHS) as established by the Health and Human Services Act (Laws 2007, LB 296).

Department staff means employees of the Department of Health and Human Services or contractors of the Department of Health and Human Services assigned those responsibilities.

Escort Services means an attendant or caregiver accompanying a minor or persons who are physically, mentally, or developmentally disabled and unable to travel or wait without assistance or supervision.

Exempt Provider means carriers exempted from PSC licensure by law including those that:

1. Transport for hire persons who are aged and their spouses and dependents under a contract with a municipality or county;
2. Are owned and operated by a nonprofit organization which has been exempted from the payment of federal income taxes as provided by Section 501(c)(4), Internal Revenue Code, and transporting solely those persons over age 60, their spouses and dependents, and/or persons experiencing disabilities;

3. Are operated by a municipality or county as authorized by law in the transportation of persons who are aged;
4. Are operated by a governmental subdivision or a qualified public purpose organization having motor vehicles with a seating capacity of 20 or less and are engaged in the transportation of passengers in the state;
5. Are engaged in the transportation of passengers and are operated by a transit authority created under and acting pursuant to the laws of the State of Nebraska; and
6. Provide escort services under contract with the Department of Health and Human Services or with any agency organized under the Nebraska Community Aging Services Act.

Individual Provider means a person who is not in the business of providing transportation for hire; for example, a friend, neighbor, or non-legally responsible relative.

Medical Escort means an attendant or caregiver accompanying a minor or persons who are physically, mentally, or developmentally disabled and unable to travel or wait without assistance or supervision to receive a Nebraska Medicaid coverable service.

Nebraska Medicaid Coverable Services means a medical service that could be covered by the Nebraska Medical Assistance Program (NMAP) as specified in Nebraska Administrative Code (NAC) Title 471 (see 473-000-200).

Tariff means the geographic and rate parameters of operation assigned to a particular carrier by the Public Service Commission.

5-018.02 Need for Service: Department staff must determine a client has the need for transportation services. Transportation services are not provided based on the demand of the client. Need for a service implies that the provision of that service will assist the client in achieving program outcomes. Eligible clients must:

1. Have no access to a working licensed vehicle or a valid driver's license;
2. Be unable to drive due to physical or cognitive limitation;
3. Be unable to secure transportation from relatives, friends, or other organizations at no cost; or
4. Require transportation in relationship to one or more of the transportation components in 473 NAC 5-018.03.

5-018.02A Medicaid Managed Care Enrollees: If the client is enrolled in one of the Medicaid Managed Care HMO plans, the HMO is responsible for authorizing transportation for the client's medical services and Department staff must not authorize medical transportation. Exception: Department staff may authorize transportation for adult day care or mental health day rehab services and for dental-related appointments and pharmacy services under Medical Transportation codes. Staff may authorize non-medical transportation for Medicaid Managed Care enrollees if the client meets the SSAD program guidelines. If the client is enrolled in one of the Medicaid Managed Care "Primary Care" plans, the responsibility for transportation authorizations remains with the Department worker.

5-018.02B Medicaid Mental Health Managed Care Enrollees: If the client is enrolled in the Medicaid Mental Health/Substance Abuse Managed Care Plan, the Mental Health/Substance Abuse Plan is responsible for authorizing transportation for mental health/substance abuse services and Department staff must not authorize mental health or substance abuse related transportation. Exception: Department staff may authorize transportation for adult day care or mental health day rehab services, and for other medical appointments under Medical Transportation codes, unless the client is enrolled in the Medicaid Managed Care HMO Program. Staff may authorize non-medical transportation for Medicaid Mental Health Managed Care enrollees if the client meets SSAD program guidelines.

5-018.02C Residents of Nursing Facilities or ICF/MR's: Residents of nursing facilities or ICF/MR's are not eligible to receive transportation through the Social Services for the Aged and Disabled (SSAD) program, except discharge transportation. All other transportation is the responsibility of the facility (nursing facility or ICF/MR). Transportation, including moving the client's household goods or personal property, may not be authorized for these clients.

5-018.03 Transportation Service Components: Transportation must be authorized only to allow a client to meet the following areas of need:

5-018.03A Medical Transportation: Medical transportation must be authorized only for a client to receive medical care under the following conditions:

1. To allow a client to receive a Nebraska Medicaid-coverable service. It is the service which must be Medicaid coverable not necessarily the provider of the service (see 473-000-200). For example, a physician visit (Medicaid coverable) at a Veterans Administration Hospital (not a Medicaid provider) would be coverable for transportation services; and
2. To allow a client to attend an adult day service program or a mental health adult day rehab program.

5-018.03A1 Medicaid eligible clients who are not eligible for SSAD Services may be eligible for medical transportation. The client must meet the need for transportation services. The client is only eligible for medical transportation services; the client is not eligible for other SSAD services or non-medical transportation services. Department staff must submit Form HHS-2A to the Central Office Transportation Coordinator for review and approval.

5-018.03A2 Medical Escort Services: Department staff must determine whether a client requires medical escort assistance. To be eligible for Medical Escort Services, the client must:

1. Be physically or mentally unable to travel or wait by him/herself to obtain a Medicaid coverable service;
2. Require assistance with personal care; or
3. Require supervision.

5-018.03B Non-Medical Transportation: This service must be authorized only for the following conditions:

1. Apply for Benefits: To allow the client to apply or be recertified for benefits and services from programs such as:
   a. Medicaid, Food Stamps, State Supplement, AABD, and SSAD Services;
   b. Social Security Administration;
   c. Veteran's Administration.
2. Shop for Food and Essential Items: To allow a client to:
   a. Shop for food;
   b. Receive commodities or food pantry services; or
   c. Obtain clothing or personal care items.
3. Obtain Legal and Financial Services: To allow the client to:
   a. Receive legal counsel from legal aid societies, private attorneys, county attorneys and other professional legal sources;
   b. Allow the client to take care of financial matters.
4. Secure Housing: To allow a client to locate, secure or retain adequate housing or independent living arrangement. Transportation may be provided for a client to return home from a hospital or nursing facility.
5. Receive SSAD Services: To allow the client transportation to and from congregate meals. (Transportation to and from Adult Day Services is covered under Medical Transportation, see 473 NAC 5-018.03A).
6. Arrange Education/training: To allow the client to make arrangements for participation in a formal educational or employment skill training program directed toward a self-support goal.
7. Secure Employment: To allow the client to locate, apply for, or secure paid employment or training leading to paid employment. DHHS does not pay for transportation to and from employment.

5-018.04 Transportation Services Provider Standards: Department staff approve provider agreements with common carriers, exempt providers, escort providers, and individual providers. To be approved, providers must meet all general provider standards in addition to the service specific standards. Department staff annually review provider agreements and renew the agreement when the provider continues to meet all provider standards and service specific standards.

5-018.04A Common Carrier Standards: The Public Service Commission certifies common carriers. Taxis and van companies are certified by the PSC as common carriers. Staff must:

1. Verify that the carrier is certified by the Public Service Commission;
2. Request and receive a copy of the carrier's tariff; and
3. Verify that the carrier has a special DHHS designation.

5-018.04B Exempt Provider Standards: Exempt providers must ensure that their employees meet the individual provider standards in 473 NAC 5-018.04D.

5-018.04C Escort Provider Standards: The provider must:

1. Be an individual age 19 or older;
2. Have training or experience in working with persons who are aged or who have a disability;
3. Have training or experience in providing personal assistance;
4. Agree to have his/her driving records reviewed, if the escort will drive;
5. Maintain information on specific needs of each client served; and
6. Report all changes observed to the client's services coordinator.

The escort provider who personally drives the client must also meet all individual provider standards in 473 NAC 5-018.04D. The escort provider must complete the individual transportation provider self-certification.

If the client requires an escort and the escort will not drive (for example, handibus, taxi, or airfare), Department staff must authorize sufficient transportation units for both the client and the escort.

5-018.04D Individual Provider Standards: Department staff are authorized to approve provider agreements with individual providers by Neb. Rev. Stat. § 75-303.03 only if the following driver and vehicle standards are met at all times when the individual is providing transportation for a client.

5-018.04D1 Driver Standards: The individual provider must:

1. Have been chosen by the client or the usual caregiver to provide transportation;
2. Be age 19 or older;
3. (Possess a current and valid driver's license;
4. Have no more than three points assessed against his/her Nebraska driver's license, or meet a comparable standard in the state where s/he is licensed to drive;
5. Currently have no limitations that would interfere with safe driving;
6. Personally drive his/her own vehicle to transport the client;
7. Use seat belts and child passenger restraint devices as required by law;
8. Not smoke while transporting the client;
9. Not transport the client while under the influence of alcohol or any drug that impairs the ability to drive safely;
10. Not provide transportation if s/he has a communicable disease which may pose a threat to the health and well-being of the client;
11. Have and maintain the minimum automobile liability and medical insurance coverage as required by law; and
12. Report disqualification from any Department program for intentional program violation.

5-018.04D2 Vehicle Standards: The individual provider's vehicle must be:

1. Currently licensed and registered as required by law;
2. Kept at all times in proper physical and mechanical conditions;
3. Equipped with operable seat belts, turn signals, lights, and horn;
4. Equipped with proper child passenger restraint devices as required by law when transporting children; and
5. Equipped to provide comfortable temperature and ventilation conditions.

5-018.04D3 Registry Checks and Criminal Background Checks: Department staff must complete and document registry checks and criminal background checks on each potential individual provider.

5-018.04D3a Registry Checks: Department staff must check:

1. Adult Protective Services Central Registry;
2. Central Register of Child Protection Cases; and
3. Nebraska State Patrol Sex Offender Registry.

If the potential provider does not reside in Nebraska or has resided in Nebraska for less than one year, Department staff must check registries in the state of residence or previous residence, if possible.

5-018.04D3a(1) Department staff must not approve a provider agreement with the potential individual provider if a report of abuse or neglect concerning the individual provider has been determined to be "Court Substantiated" or "Department Substantiated" on the APS Central Registry or "Court Substantiated", "Court Pending", or "Inconclusive" on the Central Register of Child Protection Cases.

5-018.04D3a(2) Department staff must not approve a provider agreement with a potential individual provider if the individual's name appears on the Nebraska State Patrol Sex Offender Registry.

5-018.04D3b Criminal Background Checks: Department staff must:

1. Obtain a criminal history statement from the potential individual provider; and
2. Perform a criminal history check of the potential individual provider.

5-018.04D3b(1) General Criminal History: Department staff must not approve a provider agreement with a potential individual provider if a history of convictions for misdemeanor or felony actions that endanger the health and safety of any client is indicated. This includes crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the illegal use of a controlled substance, and crimes involving moral turpitude on the part of the potential provider, or any major traffic violations.

5-018.04D3b(2) Specific Criminal History: Department staff must deny or terminate a provider agreement when conviction has occurred in the following areas:

1. Child pornography;
2. Child or adult abuse;
3. Driving under the influence: a DUI conviction within the past eight years;
4. Domestic assault;
5. Shoplifting after age 19 and within the last three years;
6. Felony fraud within the last 10 years;
7. Misdemeanor fraud within the last five years;

8. Termination of provider status for cause from any Department program within the last 10 years;
9. Possession of any controlled substance within the last five years;
10. Possession of a controlled substance with intent to deliver within the last 10 years;
11. Felony or misdemeanor assault without a weapon in the last 10 years;
12. Felony or misdemeanor assault with a weapon in the last 15 years;
13. Prostitution or solicitation of prostitution within the last five years;
14. Felony or misdemeanor robbery or burglary within the last 10 years;
15. Rape or sexual assault; or
16. Homicide.

Pending charges must be reviewed by Department staff to determine whether the client's safety is in jeopardy. Other convictions must be considered using the guidance in 473 NAC 5-018.04D3b(1) and weighted to similar offenses included in this list.

5-018.04D4 Individual Provider Approval Process: Department staff must obtain a copy of the individual's current driver's license, insurance card, and vehicle registration. The provider must complete and sign the provider self-certification and the provider agreement. In addition to having no more than three points assessed against his/her driver's license, each provider's past eight-year driving history must be considered. If a license has been suspended or revoked, the provider must not be approved for eight years from the date of suspension or revocation.

5-018.04D4a Renewal: The provider self-certification and the provider agreement must be renewed annually. The registry checks and criminal history checks required under 473 NAC 5-018.04D3 must be completed for each renewal. Department staff must obtain a copy of the individual's current driver's license, insurance card, and vehicle registration. Department staff must not renew any provider agreement with a provider whose name appears on the registries or whose criminal history check indicates any convictions as specified in 473 NAC 5-018.04D3.

5-018.04D4b Termination: Department staff must terminate the provider agreement if the individual provider is found to be in violation of any of the standards in 473 NAC 5-018.04D1 and 04D2. Department staff must terminate any provider agreement with a provider whose name appears on the registries or whose criminal history check indicates any convictions as specified in 473 NAC 5-018.04D3.

5-018.05 Authorization Procedures: Before authorizing transportation/escort services, Department staff must explore with the client the use of family, neighbors, friends, or community agencies that will provide this service without charge whenever possible. Department staff must discuss types and options of providers with the client before authorizing transportation services. Department staff must assure the client is aware of the associated costs.

5-018.05A Medical Transportation: Department staff must offer the client choice of providers for medical transportation.

5-018.05B Transportation for Out-of-State Medical Treatment: Medicaid may cover transportation for out-of-state medical treatment for Medicaid-eligible clients.

If out-of-state treatment is approved by Medicaid, Department staff may authorize transportation. The client is not eligible for transportation assistance if the client is driving him/herself.

If out-of-state treatment is not approved because of a non-medical reason such as the out-of-state provider refusing to participate in Medicaid, transportation for out-of-state treatment may be approved (see 473 NAC 5-018.05B2). If out-of-state treatment is not approved for lack of medical necessity, transportation for out-of-state treatment must not be approved.

If prior authorization for out-of-state treatment is not required (for example, receiving services in a border state), Department staff may authorize transportation under the usual procedures.

5-018.05B1 Medicare (Primary) and Medicaid (Secondary): If the client has Medicare as his/her primary insurance and Medicaid is secondary, the client does not require out-of-state treatment approval from Medicaid. The DHHS Central Office Transportation Coordinator will determine if out-of-state transportation assistance is approved. The Coordinator must use components of the definition of medical necessity found in 471 NAC 1-002.02A to determine whether out-of-state transportation may be authorized. If out-of-state transportation assistance is disapproved because the client is requesting routine medical services (for example, using a distant out-of-state clinic as the primary care provider), Department staff must deny the transportation service.

5-018.05B2 Private Health Insurance (Primary) and Medicaid (Secondary): If the client is using private insurance as his/her primary insurance and Medicaid is secondary, Medicaid prior authorization of the out-of-state medical treatment is required.

If out-of-state treatment is approved by Medicaid, Department staff may authorize transportation. The client is not eligible for assistance if the client is driving him/herself.

If Medicaid denies prior authorization of payment for out-of-state treatment because of a non-medical reason such as the out-of-state provider refusing to participate in Medicaid, Department staff must request prior authorization from the DHHS Central Office Transportation Coordinator. If the Coordinator denies out-of-state transportation, Department staff must deny the transportation service. If the Coordinator approves the out-of-state transportation, Department staff must approve the transportation service.

If Medicaid denies prior authorization for out-of-state treatment due to lack of medical necessity, transportation for out-of-state treatment must also be denied.

5-018.05C Non-Medical Transportation: For areas where exempt providers are available or the client has chosen to use an individual provider, the client will not be allowed to use common carriers unless the exempt or individual provider cannot provide the service.

5-018.05D Authorization of Exempt Providers: Department staff may approve a provider agreement with and authorize services for a provider who is exempt from PSC licensure as appropriate to meet a client's needs. The availability of a common carrier does not limit the use of an exempt provider.

5-018.05E Medical Escort: Department staff must use the following criteria to determine when to authorize an hourly rate for medical escort services:

1. The escort is not a legally responsible member of the client's family;
2. The client is not able to secure an escort at no cost; and
3. The escort is not receiving payment from another source.

5-018.05E1 Utilization of Exempt Providers as the Driver: When transportation is provided by an exempt provider, Department staff may authorize the cost of the escort's transportation only if there is an extra charge for the escort's transportation, such as air fares, rural transit system, city bus systems, etc.

5-018.05E2 Utilization of Common Carrier: When transportation is provided by common carrier provider, the provider may not charge an extra cost for transporting the escort.

5-018.05E3 Utilization of Individual Providers as the Driver: When transportation is provided to a client and an escort by an individual provider, the provider will not be paid an additional amount for transporting the escort.

5-018.05F Individual Providers: Department staff must authorize an individual provider if the following criteria are met:

1. The client has chosen the individual provider;
2. The individual will personally drive the vehicle; and
3. The individual meets provider standards in 473 NAC 5-018.04D.

5-018.06 Transportation Services Rates, Frequency, and Maximum Allowable Units

5-018.06A Conditions for Payment: The Department will pay for transportation services only:

1. When the client is actually in the vehicle; and
2. Using the most direct and logical route from the client's residence to the service location.

5-018.06B Upper Limits: DHHS Central Office establishes transportation rates according to the following limits. Department staff assigned resource development responsibilities may negotiate rates lower than the established rates.

5-018.06B1 Common Carriers: Neb. Rev. Stat. § 75-303.02 limits the distance rates for common carriers at a rate no greater than three times the state employee mileage rate. The maximum reimbursement rate does not apply when the carrier:

7. Transports the client wholly within the corporate limits of the city or village where the transportation of the client originated; or
8. Transports a disabled person as defined by the federal Americans with Disabilities Act of 1990 in a vehicle that is compliant with the regulations for the transportation of the disabled person.

5-018.06B2 Taxis: Taxi rates may be no greater than 95% of published rates.

5-018.06B3 Exempt Providers: DHHS Central Office will establish rates for exempt providers.

5-018.06B4 Escort Providers: The mileage rate for escort providers must not exceed the state employee mileage rate unless the escort is a certified carrier. The hourly rate is set by DHHS Central Office.

5-018.06B5 Individual Providers: As provided in Neb. Rev. Stat. § 75-303.03, the Department of Health and Human Services will reimburse the individual provider for costs incurred in transportation at a rate no greater than that paid for reimbursement of state employees under Neb. Rev. Stat. § 81-1176.

5-018.06C Frequency: The frequency for medical and non-medical transportation is by miles or trip. The frequency for medical escort services is by:

1. The hour(s) and miles; or
2. The hours and trip.

Department staff must authorize time and miles traveled separately.

5-018.06D Maximum Allowable Units: Department staff must authorize transportation units based on client need not to exceed the following limits:

1. Non-medical Transportation:
   a. 50 miles per one way trip;
   b. One round trip per week for shopping for food and essential items;
   c. Two round trips per month for necessary business; and/or
   d. One round trip per day for congregate meals.
2. Medical Transportation: Based on needed treatment and care.

5-019 Special Services for Mentally Retarded Persons

5-019.01 Introduction: Nebraska's six Community-Based Mental Retardation Programs (CBMRs) are responsible for providing needed services to mentally retarded persons regardless of the individual's financial situation. This section contains instructions for CBMR staff members to follow in providing Special Services for Mentally Retarded Persons.

5-019.01A Service Goals: The goals related to Special Services for Mentally Retarded Persons are -

1. Achieving or maintaining economic self-support (Goal 1);
2. Achieving or maintaining self-sufficiency (Goal 2);
3. Preventing or remedying neglect, abuse, or exploitation (Goal 3);
4. Preventing or reducing inappropriate institutional care (Goal 4); and
5. Securing referral and admission for institutional care (Goal 5);

5-019.02 Definition of Special Services for Mentally Retarded Persons: Service components include -

1. Day Services - Adult: Vocational services, sheltered workshop, work station in industry, community living/integration training, and day activities program;
2. Day Services - School Age (16-21): Same as above, except no day activities program;
3. School Age Services (5-21): Child development center and in-home training;
4. Pre-School Services (0-5): Same as School Age Services;
5. Residential Services - Adult (age 19 and older): Adult training for independent living;
6. Residential Services - Children (age 18 and younger): Training for social behavior skills achievement; and
7. General Services: Social services, follow-along assistance/enabler, facilitator assistance, physical therapy, speech therapy, recreation, transportation, and respite/emergency.

5-019.03 Delegation of Authority to Community-Based Mental Retardation Programs (CBMR): Under annual agreements between NDSS and the six Mental Retardation Regions, the CBMR Programs shall -

1. Determine individual's eligibility for Special Services for Mentally Retarded Persons;
2. Authorize and provide appropriate Special Services for Mentally Retarded Persons; and
3. Comply with all provisions of their annual agreements with NDSS.

5-019.04 Clients Served: Eligibility categories for Special Services for Mentally Retarded Persons are -

1. Current recipients of SSI or State Supplemental (CD); or
2. All other mentally retarded individuals in need of service (MD).

5-019.05 Service Units and Codes

Service Description	Unit Provided	Service Code
Day Services - Adult		
Vocational Services	Hour in Direct Service	1904
Sheltered Workshop (Regular Program	Hour in Direct Service	1905
Work Station in Industry (WSI)	Hour in Direct Service	1906
Community Living/Integration Training	Hour in Direct Service	1907
Day Activities Program	Hour in Direct Service	1908
Day Services - School Age (16-21)		
Vocational Services	Hour of Direct Service	1914
Sheltered Workshop (Regular Program)	Hour of Direct Service	1915
Work Station in Industry (WI)	Hour of Direct Service	1916
Community Living/Integration Training	Hour of Direct Service	1917
School Age Services (5-21)		
Child Developmental Center	Hour of Direct Service	1940
In-Home Training	Hour of Direct Service	1941
Pre-School Services (0-5)		
Child Developmental Center	Hour of Direct Service	1950
In-Home Training	Hour of Direct Service	1951
Residential Services - Adult (age 19 and older)		
Adult Training for Independent Living	Night/Day of Training	1920
Residential Services - Children (age 18 and younger)		
Training for Social Behavior Skills Achievement	Night/Day of Training	1960
General Services		
Social Services/Case Management plus Direct Services	Significant contact or contacts during month with or on behalf of the client	1980

Service Description	Unit Provided	Service Code
Social Services/Case Management Only plus Direct Services	Significant contact or contacts during month with or on behalf of the client	1981
Follow-along Assistance/Enabler, Facilitator Assistance	Significant contact during day with or on behalf of the client. Counted as one per day when service is received.	1982
Physical Therapy	Number of days during month that client receives direct services	1983
Speech Therapy	Number of days during month that client receives direct service	1984
Recreation	Number of days during month that client receives direct service	1985
Transportation	Number of miles transported during month to and from vocational facilities	1986
Respite/Emergency	One night in respite or emergency placement	1987

5-019.06 Local Service Unit Responsibilities: Local unit staff shall -

1. Provide mentally retarded persons with information and referral to the appropriate CBMR;
2. Respond to requests from CBMR staff for written confirmation of an applicant's SSI or State Supplemental Status; and
3. Determine eligibility and authorize social services to meet the needs of eligible mentally retarded individuals for services other than Special Services for Mentally Retarded Persons. Note: Transportation may not be authorized for CBMR programs. See 473 NAC 5-018.08.

5-019.07 CBMR Case Management Responsibilities: CBMR staff shall -

1. Not be required to use Form DSS-3A, "Social Services Application," when determining Title XX eligibility, but may use their standard application form for their intake when determining an individual's eligibility for Special Services for Mentally Retarded Persons.

2. Determine that an applicant is either eligible through Title XX for Special Services for Mentally Retarded Persons as a current recipient of SSI or State Supplemental assistance ("CD"), or eligible for CBMR services on the basis of the CBMR's eligibility criteria ("MO"), or ineligible for Special Services for Mentally Retarded Persons;
3. Obtain verification of mental retardation diagnosis before declaring eligibility for, and authorizing, Special Services for Mentally Retarded Persons through Title XX;
4. Document in an applicant's file a finding of eligibility, ineligibility, or termination of eligibility. This documentation must also be provided in writing to a client, client's representative, or guardian, when applicable;
5. Not deny anyone the right to apply for Special Services for Mentally Retarded Persons; and
6. Change a client's eligibility classification code from "CD" to "MD" or vice versa only at the time of eligibility redetermination. A change in eligibility classification is needed when a client either becomes, or is terminated as, a current recipient of SSI or State Supplemental assistance. Because CBMRs must continue to serve clients in need, regardless of eligibility classification, any change in codes is unnecessary until the customary eligibility redetermination process is conducted.

CBMR staff shall also refer to the OMR publication, "Rules, Regulations, and Minimum Standards for Programs, Facilities, or Services Funded in Whole or in Part Through the State Office of Mental Retardation."

5-010.08 Case Record Maintenance: CBMR staff shall retain case records for at least four years. Service case records must contain at least the following:

1. A written application for CBMR services;
2. A written diagnosis of mental retardation;
3. Income verification if there is reason to question a client's status as a current SSI or State Supplemental recipient;
4. Narrative documentation of needs assessment, service planning, and client evaluation;
5. Documentation of service eligibility, ineligibility, or termination of eligibility; and
6. Documentation of service provision (e.g., attendance sheets).

CHAPTER 6-000 SUPPORTIVE SERVICES

6-001 Adult Family Home

6-001.01 Introduction: This section contains material which relates to -

1. Recruitment, evaluation, and approval of adult family homes; and
2. Providing case management services for all adult family home guests.

Adult family homes provide a living arrangement to meet the needs of guests who are unable to live independently but who can function adequately with minimal supervision and protection in a home-like living arrangement. Adult family homes enable adults to continue maximum normal functioning within a community.

6-001.02 Adult Family Home Definitions

Adult Family Home: An adult family home (AFH) is a residential living unit certified by NDSS to provide full-time residence and minimal supervision and guidance to not more than three guests age 19 or older. Service includes board and room with meals, standard furnishings, equipment, household supplies, laundry service, and facilities to ensure client comfort.

Adult Family Home Guest: An adult family home guest is a resident, age 19 or older, whose needs are most appropriately met in an adult family home.

Adult Family Home Sponsor - An adult family home sponsor is an adult, age 19 or older, who manages and provides caretaker responsibilities in an adult family home. The sponsor accepts responsibility for maintaining the facility and meeting the needs of the guests.

Supervision: Each sponsor defines supervision for his/her home by indicating acceptable guest conditions on Form DSS-0750, "Adult Family Home Application."

6-001.03 Self-Administration of Medication: The sponsor and the worker assigned responsibility for case management shall ensure that no adult family home guest has health conditions or handicaps which require ongoing medical treatment and supervision other than self-administered medications and physician office visits. An adult who requires an occasional reminder to take medications may be appropriate for adult family home care.

If a guest requires temporary assistance with administration of medication, the guest's physician shall provide written approval for the guest to reside in the adult family home and for the sponsor to assist with the administration of the medication.

6-001.04 Complaints of Suspected Abuse/Neglect Occurring in Adult Family Homes: Staff shall report all complaints of adult abuse/neglect occurring in adult family homes. (See 473 NAC 5-015.)

6-001.04A Complaint Status: Upon receipt of a completed investigative report (except unfounded) in an adult family home, the resource development worker shall arrange a conference with the worker who completed the investigation. This conference must include -

1. A discussion of the nature and extent of the abuse/neglect;
2. The duration;
3. Whether the guest is a high risk or in a life-threatening situation; and
4. Development of a plan of action.

If the sponsor is responsible, either fully or in part, for the abuse/neglect, the worker shall explore all possible remedies with the sponsor and the guests and develop a plan of action. If the abuse/neglect has not been alleviated after a reasonable period of time not to exceed 30 days, the worker shall terminate the AFH certification.

6-001.04B High Risk Situations: In situations where the abuse/neglect is life-threatening or of high risk to the guest or it is court substantiated that the sponsor perpetrated the abuse/neglect, the worker shall terminate the AFH certification immediately.

The worker shall refer all guests or their guardians to Alternate Care Services whenever an AFH certificate is terminated as the result of abuse/neglect.

See 473 NAC 6-001.07F for termination procedures.

6-001.05 Adult Family Home Sponsor Responsibilities: Each adult family home sponsor shall -

1. Accept guests only through the direction of, or in cooperation with, local service unit staff;
2. Comply with the provisions of Title VI of the Civil Rights Act of 1964 and its amendments;
3. Agree to share required information with, and follow the directions and suggestions of, agency representatives regarding the guest's functioning;

4. Allow agency staff to visit the adult family home at any reasonable time;
5. Arrange for substitute supervision in the home (e.g., if the sponsor is absent because of illness or a death in the family). The sponsor shall notify and receive prior approval from the local unit before arranging substitute supervision. The sponsor shall accept responsibility for reimbursing any substitute care provided;
6. Arrange for guests' access to the home (e.g., in the event of a guest's illness);
7. Maintain a record of important information about each guest including the name and telephone number of the guest's doctor, or clinic, the guest's hospital and pharmacy preference, and his/her medication schedule (if any);
8. Report any changes in the sponsor's address, family members, telephone number or number of guests to resource development before the change occurs;
9. Contact the Internal Revenue Service to determine, if additional information is necessary, whether income from adult family home care will need to be considered for tax purposes; and
10. Contact his/her insurance agent when looking for a policy to protect from liability in case a guest is injured. Insurance companies vary in the type of benefits and coverage offered.

6-001.06 Financial Arrangements for Adult Family Home Care: Guests who are clients of NDSS, may be paying for adult family home care with public assistance funds. These funds are unrestricted; there is no stipulation as to how the money is spent. The Department suggests that the amount be reserved for the client's personal needs. Therefore, the reimbursement each adult family home receives is negotiated between the sponsor and the guest (and/or his/her legal representative or worker).

Sponsors may assist guests in money management, but may not act as guardians, conservators, representative payees, or have power of attorney for any of their guests. Exception: A sponsor may act in an above capacity for a guest to whom s/he is related.

6-001.07 Resource Development Functions

6-001.07A Recruitment Responsibilities: Local staff shall -

1. Recruit adult family home sponsors;
2. Promote the Adult Family Home Program through an ongoing public information campaign.
3. Inform interested sponsors about adult family home orientation and training opportunities; and
4. Maintain records which identify vacancies in AFHs, give description of the AFH, etc.

6-001.07B Evaluation and Certification Procedures: Local staff shall -

1. Receive referrals for adult family home approvals from case management staff, other agencies, clients' relatives, or other individuals;
2. Conduct an interview visit with each applicant;
3. Explain evaluation process of both the home and sponsor(s) and yearly evaluation requirement to each applicant;
4. Explain and interpret policies, requirements, and standards with which each applicant and home must comply;
5. Assist each applicant to complete Parts I and II of Form DSS-0750, "Adult Family Home Application."
6. Provide applicants with Form DSS-0751, "Medical Report," when necessary;
7. Complete the evaluation procedure using Form DSS-0754, "Evaluation of Adult Family Home," and a written narrative containing pertinent information regarding the evaluation of the home and the sponsor(s). In completing the evaluation, the resource developer shall determine whether each applicant meets the necessary standards in 471 NAC 6-001.09 and shall assess the ability of the sponsor(s) to -
   a. Provide a stable home life for the guest;
   b. Understand the guest's strengths and weaknesses;
   c. Exhibit concern for the guest's welfare;
   d. Help the guest reach his/her personal goals; and
   e. Work willingly with social services workers, community organizations, and people interested in the Adult Family Home Program;
8. Secure each applicant's signature on Form DSS-0752, "Adult Family Home Agreement";
9. Determine whether a fire inspection or health department inspection is necessary (e.g., when the adult family home use basement bedrooms for guests, the sanitation of the home is questionable, or there are exposed wires in the home), and arrange for the inspection(s) using Form DSS-0753, "Adult Family Home Inspection Referral." If any other inspections are necessary, the worker shall instruct the sponsor to arrange for the required inspection(s);
10. Determine approval or disapproval;
11. Complete Part III of Form DSS-0750;
12. If approved, issue Form DSS-0755, "Adult Family Home Certificate," effective up to 12 months;
13. If disapproved, notify applicant; and
14. Route proper forms to the sponsor, the local service unit, Central Office, and each guest's county of legal settlement.

6-001.07C Annual Certification: Staff shall re-evaluate approved adult family homes annually before the expiration of the certification. Upon re-evaluation, the worker at his/her discretion may require another medical examination if the sponsor's physical or local staff believe it is necessary.

6-001.07D Change of AFH Address: Whenever an AFH sponsor changes his/her address, the resource development worker shall complete an evaluation of the new home. The evaluation must be completed before the move or within five days after the move, if the sponsor's certification is to continue.

The worker shall complete and properly route the following forms:

1. Form DSS-0750;
2. Form DSS-0752 (not necessary if the existing agreement covers the certification period);
3. Form DSS-0754; and
4. Form DSS-0755.

6-001.07E Increase in the Number of Residents: When an AFH sponsor wishes to increase the number of guests for whom s/he is certified, the worker shall complete an evaluation of the sponsor's ability to handle additional guests and whether there is adequate space available in the home.

The worker shall complete and properly route the following:

1. Form DSS-0750;
2. Form DSS-0751 (at worker's discretion);
3. Form DSS-0752 (not necessary if existing agreement covers the certification period);
4. Form DSS-0754; and
5. Form DSS-0755.

6-001.07F Termination of Approval: Whenever an AFH sponsor or home is in violation of AFH regulations, the worker shall allow the AFH sponsor the opportunity to correct the violation within a reasonable time, not to exceed 30 days. If the violation has not been corrected within that time, the worker shall terminate the AFH certificate.

To terminate an AFH approval, either at the sponsor's request or due to a resource development decision (i.e., in violation of regulations, abuse, neglect, or exploitation), the worker shall note the termination date on Form DSS-0750 and route it to the family home sponsor, to the county office, to Central Office, and to each guest's county of finance (when applicable). The worker shall notify the sponsor of the termination in writing and require the return of Form DSS-0755.

The worker shall notify all guests of termination and refer them for Alternate Care Service. (See 473 NAC 6-001.04 for abuse/neglect situations.)

6-001.08 Case Management Functions: Local staff assigned case management responsibilities shall complete the following procedures to ensure that adult family home guests receive appropriate care:

1. Require a potential adult family home guest or his/her representative to present any documentation regarding his/her medications which the worker feels is necessary to make a decision about the amount of care required in relation to the guest's medication needs. If the worker questions the guest's ability to self-administer his/her medication, the worker shall direct the guest to contact his/her physician. If the physician feels self-administration is safe, the guest shall obtain a written statement from the physician for the unit's files;
2. Inform the sponsor (with the consent and input of the guest) of the guest's background, medical history, special need, etc.;
3. Assist the sponsor to assess the client's needs and appropriateness for adult family care before admission. The worker may require the sponsor to furnish a written needs assessment;
4. Help arrange visits between potential guests and sponsors before admission to the adult family home in order for sponsors and guests to assess their compatibility;
5. Inform the guest's county of legal settlement (if applicable) if the guest moves;
6. Arrange, when necessary, for a guest's movement into an adult family home;
7. Explain payment procedures for adult family home care to sponsors and guests and assist them in making financial arrangements for the guest's living expenses;
8. Visit the AFH to assess the appropriateness of the living arrangement and the guest's adjustment; and
9. Offer services and develop a service plan with the guest when s/he has service needs beyond those the sponsor can meet (e.g., transportation and adult protective services).

6-001.09 Standards for Adult Family Home Approval: Adult family homes and sponsors shall meet the standards described in this subsection.

6-001.09A Adult Family Home Sponsors: All AFH sponsors shall -

1. Be physically and mentally capable of assuming the responsibilities and functions involved in adult family care. A medical examination is required before the initial certification. Thereafter, the examination is at the resource developer's discretion.
2. Be capable of exercising good judgment in supervising adults and in cooperating with the local service office;
3. Conform with all local, state, and federal fire, sanitation, and zoning standards;

4. Arrange for any inspection required by the resource developer (see 473 NAC 6-001.07B, item 9);
5. Accept responsibility and potential liability for guest safety and property security; and
6. Including other adult household members, not have engaged in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides an AFH living arrangement. This may include a substantiated listing as a perpetrator on the child and/or adult Central Registries of abuse and neglect.

6-001.09B Adult Family Home Environmental Requirements

6-001.09B1 Bedrooms: The AFH sponsor shall furnish each guest with a private or semi-private bedroom having -

1. A minimum of 80 square feet per occupant in a single room;
2. A minimum of 60 square feet per occupant in a double room;
3. A single or double bed for each guest with a mattress and springs in good condition;
4. At least three feet between beds at all points;
5. Adequate and convenient room, closet, and drawer space and clean, adequate bedding which is changed at least weekly;
6. Adequate provision for the guest's privacy. Guests of opposite sexes must not be required to share a bedroom; and
7. A first floor location for any guest for whom another location might be unsafe.

6-001.09B2 Bathrooms: Bath, lavatory, and toilet facilities must be easily accessible and available to residents. Adequate amounts of bar soap, toilet tissue, and facial tissue must be provided.

6-001.09B3 Common Areas: A well-lighted, well-ventilated, and heated living room must be available for the use of guests and their visitors for social and recreational purposes.

6-001.09C Fire Safety Requirements: All homes must meet existing state and local fire prevention standards. The AFH sponsor shall ensure that the adult family home is in sufficient repair to not constitute a fire hazard. Smoke detection devises, in good working order, are recommended.

Sponsors shall develop a written fire evacuation plan which is routinely explained to and practiced with the guests. If the basement has no outdoor exit, the resource development worker shall evaluate the guests' physical limitations and the sponsor's evacuation plan before approving the home. The worker may require a fire inspection to determine the appropriateness of having basement bedrooms for guests' use.

6-001.09D Sanitation Requirements: AFH sponsors shall carry out accepted sanitation practices, provide necessary household cleaning supplies, and meet state and local health standards.

6-001.09E Meal Preparation: The AFH sponsor shall observe adequate nutrition standards and food handling sanitation practices in preparing and serving meals. Three meals a day must be available for guests.

6-001.09F Laundry Facilities: Sponsors shall provide laundry services for their guests using either facilities in the home or commercial laundry facilities. The sponsor is not responsible for dry cleaning costs.

6-001.10 Adult Family Home Forms and Instructions: Staff shall use the following forms and instructions for initial and annual evaluations and certification of adult family homes:

1. Form DSS-0750, "Adult Family Home Application" (473-000-70);
2. Form DSS-0751, "Medical Report - Adult Family Home Sponsor" (473-000-71);
3. Form DSS-0752, "Adult Family Home Agreement" (473-000-72);
4. Form DSS-0753, "Adult Family Home Inspection Referral" (473-000-73);
5. Form DSS-0754, "Evaluation of Adult Family Home" (473-000-74); and
6. Form DSS-0755, "Adult Family Home Certificate" (473-000-75).

6-002 Reporting Unlicensed Facilities and Homes

6-002.01 Local Unit Responsibilities: Any NDSS staff person who determines that a facility or home serving more than three individuals is not licensed by the Nebraska Department of Health shall submit Form DSS-0926, "Request for State Health Department Investigation," to -

Director, Division of Licensure and Standards
Department of Health
301 Centennial Mall South, Third Floor
Lincoln, NE 68509

The referral must include -

1. The facility's name, address, and telephone number;
2. The names and number of individuals being served by the facility; and
3. The name, office, and telephone number of a worker the health department may contact, if necessary. Coordination must take place within the office to avoid duplicate referrals. One staff person may be assigned responsibility for notifying the health department.

6-002.02 Department of Health Responsibilities: The Division of Licensure and Standards will, upon receipt of a referral -

1. Investigate the report;
2. Report the results of the investigation on the referral form and submit it to Central Office; and
3. Report updates to the licensed facilities roster to Central Office on a monthly basis.

6-002.03 Central Office Responsibilities: Central Office staff shall -

1. Receive completed referrals from the Department of Health;
2. Send an update of facility rosters to county offices on a routine basis; and
3. Provide technical assistance to counties.