CLE FOR ALJS AND SHOS AT 330 WEST 34TH ST, MANHATTAN

Topic: Traumatic Brain Injury

Place: 330 West 34th Street, NY, NY (5th Floor Conference Room)

Date: April 20, 2007

Time: 10:15am – 12:15 pm (one 10 minute break)

This course will be eligible for 2 hours of non-transitional credits in Areas of Professional Practice

Attendance: All ALJs and SHOs stationed at our 34th St office are expected to attend unless excused by their supervisor.

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Attorney Evaluations

Continuing Legal Education Evaluations
"Traumatic Brain Injury"
Course date: April 20, 2007

Please complete this form following the Continuing Legal Education Course. **Thank you!**

Directions: Please circle the appropriate answer or ranking.

Are you taking this course to fulfill your Mandatory Continuing Legal Education requirements?	Yes	No	N/A
Should we offer this course in the future?	Yes	No	N/A
Would you recommend this course to a colleague?	Yes	No	N/A

	Poor		Average		Excellent
How would you rate this session?	1	2	3	4	5
How would you rate the instructors?	1	2	3	4	5
How would you rate the quality of this training?	1	2	3	4	5
How would you rate the quality of this facility?	1	2	3	4	5
How would you rate the written materials?	1	2	3	4	5

What did you like about this course?

Do you have any suggestions that would improve this course?

Do you have any suggestions for future CLE courses?

Name(Optional):

Agenda for Traumatic Brain Injury
330 West 34th Street, New York, NY
April 20, 2007
10:15 PM -12:15 PM

Panelists:

Pat Greene- Gumson -	Director Home and Community Based Services for Individuals with Traumatic Brain Injury (HCBS) Medicaid Waiver Program
Shirley Gnacik -	Director of TBI Housing Program
Patricia Sheppard	NYS Counsel Office representative for HCBS/TBI waiver program
Helen Callahan	Manages Fair Hearing for the HCBS/TBI waiver program
10:15-10:30	Pat Gumson What is a Brain Injury
10:30-11:05	Pat Gumson - History, administration and over-view of the TBI waiver program
11:05- 11:15	Break
11:15-11:45	Shirley Gnacik - TBI Housing Program Waiver Participant Subsidy Contract
11:45-12:15	All Panelists: Questions, Discussion, Fair Hearing Issues,

Shirley Gnacik

TBI Housing Program
518-474-6580

Ms Gnacik is a registered nurse who has been working for NYS since 1987 when she started in the Personal Care Program. She was one of the nurses in 1993 that visited New York State residents with traumatic brain injury who were placed in out-of-state rehabilitation facilities. She has been overseeing the Traumatic Brain Injury Housing Program since 2003. In the past year she has also become involved in assisting Pat Greene-Gumson in the administration of the Home and Community Based Services for Individuals with Traumatic Brain Injury Medicaid Program.

Pat Greene Gumson

Director, Traumatic Brain Injury (TBI) HCBS Medicaid Waiver Program
474 6580

Ms Gumson is a R.N. graduate of the NYU / Bellevue School of Nursing

She has worked in the field of brain injury for over twenty years in various capacities i.e.: Intensive Care, Acute Care, Rehabilitation Nursing and Home Care. Prior to joining the Department of Health in 1993 to work on the implementation of the TBI Waiver, Pat was the Coordinator of the first State Ed project to assist children , schools and families after brain injury, was Head Injury Services Coordinator at the Southern Tier Independence Center , worked as a Family Services Coordinator for the New York State Brain Injury Association and served as co chair of the association's legislative committee , and founded the NYS TBI Coalition which resulted in passage of the 1994 TBI Legislation. She is currently the Principal Investigator for a Federal Grant to New York State designed to meet the needs of military persons returning from Iraq and Afghanistan with brain injuries .

Patricia Sheppard

Patricia Sheppard is a Senior Attorney with the New York State Department of Health, Bureau of Heath Insurance Programs. Prior to joining the Health Department, she was with House Counsel at the New York State Division of Taxation and Finance. Ms. Sheppard received her B.A. from the University of Michigan and her J.D. from Vermont Law School.

Helen M. Callahan

Health Program Administrator
(518) 474-6580

Helen has a Master of Business Administration degree from Russell Sage College and a Bachelor of Science degree in Business Administration from The College of St. Rose.

Currently, Helen works in the New York State Department of Health for the Statewide Medicaid Home and Community Based Services Waiver Program for persons with Traumatic Brain Injury (TBI). She oversees and coordinates the administrative functions of ten Regional Resource Development Centers for the TBI program, including oversight of program contracts, budgets, expenditure plans, and contract deliverables, as well as prepares respective reports on the TBI Program to the Centers for Medicare and Medicaid Services. In addition, Helen is a liaison with the Office of Temporary and Disability Assistance for TBI Fair Hearings.

Helen also worked in the Long Term Home Health Care Program for the New York State Department of Health and provided technical assistance to Local Departments of Social Services and providers of the program. In addition, Helen assisted in the development of a program manual to convey rules and policies, and worked with clients and families to resolve issues with services.

Additionally, Helen has worked with various agencies such as the former New York State Energy Office, the State Office of General Services, and State Education Department, in the areas of project/contract management, procurement, program research and design, human resource management and marketing.

LAWS OF NEW YORK, 1994
CHAPTER 196

AN ACT to amend the public health law, in relation to creating a program for traumatic brain injury and creating the traumatic brain injury services coordinating council

Became a law June 20, 1994, with the approval of the Governor.

Passed by a majority vote, three-fifths being present.

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Legislative findings and purpose. The legislature hereby recognizes that each year several thousand New York state residents sustain a traumatic brain injury, the majority of which are the result of vehicular and traffic-related accidents.

It is also hereby acknowledged by the legislature that due to the complexity of a traumatic brain injury, individuals who need coordinated and specialized services are either overlooked, excluded or inadequately served by health and social services organizations. Additionally, coordination among these service providers is lacking. Many persons with traumatic brain injury are forced to obtain services at great emotional and financial cost from facilities outside their home communities. Services that do exist are often limited in geographical distribution and are not easily accessible.

The legislature finds that there is an immediate need for a statewide comprehensive program for persons with traumatic brain injury.

In recognition of the intent of New York state to continue to promote the health, safety and welfare of all the citizens of this state, the department of health shall develop, promote and encourage community-based health care, educational, vocational, rehabilitation, family support and other essential services for persons with traumatic brain injury and their families.

S 2. The public health law is amended by adding a new article 27-CC to read as follows:

ARTICLE 27-CC

NEW YORK STATE TRAUMATIC BRAIN INJURY PROGRAM

S 2740. TRAUMATIC BRAIN INJURY PROGRAM. THE DEPARTMENT SHALL HAVE THE CENTRAL RESPONSIBILITY FOR ADMINISTERING THE PROVISIONS OF THIS ARTICLE AND OTHERWISE COORDINATING THE STATE'S POLICIES WITH RESPECT TO TRAUMATIC BRAIN INJURY, IN CONSULTATION WITH THE OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, THE OFFICE OF MENTAL HEALTH, THE DEPARTMENT OF EDUCATION, THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, THE DEPARTMENT OF SOCIAL SERVICES, THE OFFICE OF THE ADVOCATE FOR THE DISABLED AND THE COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED.

S 2741. DEFINITIONS. AS USED IN THIS ARTICLE, THE TERM "TRAUMATIC BRAIN INJURY" MEANS AN ACQUIRED INJURY TO THE BRAIN CAUSED BY AN EXTERNAL PHYSICAL FORCE RESULTING IN TOTAL OR PARTIAL DISABILITY OR IMPAIR-

MENT AND SHALL INCLUDE BUT NOT BE LIMITED TO DAMAGE TO THE CENTRAL NERVOUS SYSTEM FROM ANOXIC/HYPOXIC EPISODES OR DAMAGE TO THE CENTRAL NERVOUS SYSTEM FROM ALLERGIC CONDITIONS, TOXIC SUBSTANCES AND OTHER ACUTE MEDICAL/CLINICAL INCIDENTS. SUCH TERM SHALL INCLUDE, BUT NOT BE LIMITED TO, OPEN AND CLOSED BRAIN INJURIES THAT MAY RESULT IN MILD, MODERATE OR SEVERE IMPAIRMENTS IN ONE OR MORE AREAS, INCLUDING COGNITION, LANGUAGE, MEMORY, ATTENTION, REASONING, ABSTRACT THINKING, JUDGMENT, PROBLEM-SOLVING, SENSORY PERCEPTUAL AND MOTOR ABILITIES, PSYCHO-SOCIAL BEHAVIOR, PHYSICAL FUNCTIONS, INFORMATION PROCESSING AND SPEECH. SUCH TERM SHALL NOT INCLUDE PROGRESSIVE DEMENTIAS AND OTHER MENTALLY IMPAIRING CONDITIONS, DEPRESSION AND PSYCHIATRIC DISORDERS IN WHICH THERE IS NO KNOWN OR OBVIOUS CENTRAL NERVOUS SYSTEM DAMAGE, NEUROLOGICAL, METABOLIC AND OTHER MEDICAL CONDITIONS OF CHRONIC, CONGENITAL OR DEGENERATIVE NATURE OR BRAIN INJURIES INDUCED BY BIRTH TRAUMA.

S 2742. FUNCTIONS, POWERS AND DUTIES OF THE DEPARTMENT. THE DEPARTMENT SHALL HAVE THE FOLLOWING POWERS AND DUTIES:

1. TO DEVELOP A COMPREHENSIVE STATEWIDE PROGRAM THAT INCLUDES MEDICAL, HOUSING, VOCATIONAL, EDUCATIONAL, TRANSPORTATION, SOCIAL, PERSONAL CARE, FAMILY SUPPORT, DAY PROGRAM SERVICES, COMMUNITY RE-ENTRY SERVICES, OUTPATIENT REHABILITATION SERVICES AND OTHER ESSENTIAL SERVICES;

2. TO DEVELOP OUTREACH SERVICES TO PROVIDE COORDINATED INFORMATION REGARDING ASSISTANCE AVAILABLE TO PERSONS WITH TRAUMATIC BRAIN INJURY AND THEIR FAMILIES;

3. TO DEVELOP AND MAINTAIN A CLEARINGHOUSE OF INFORMATION ON TRAUMATIC BRAIN INJURIES, INCLUDING BUT NOT LIMITED TO, RESOURCES THAT SUPPORT THE DEVELOPMENT AND IMPLEMENTATION OF COMMUNITY-BASED SERVICES AND REHABILITATION;

4. TO TRACK THE AMOUNT OF AND COST OF SERVICES PROVIDED TO PERSONS WITH TRAUMATIC BRAIN INJURY PLACED IN OUT-OF-STATE TREATMENT SETTINGS;

5. TO DEVELOP INNOVATIVE EDUCATIONAL PROGRAMS ON THE CAUSES AND PREVENTION OF TRAUMATIC BRAIN INJURIES, WITH AN EMPHASIS ON OUTREACH CAMPAIGNS. SUCH PROGRAMS AND INFORMATION SHALL INCLUDE, BUT NOT BE LIMITED TO, TREATMENT AND SERVICES FOR PERSONS WITH TRAUMATIC BRAIN INJURY AND THEIR FAMILIES;

6. TO ACCEPT AND EXPEND ANY GRANTS, AWARDS OF OTHER FUNDS OR APPROPRIATIONS AS MAY BE AVAILABLE FOR THESE PURPOSES, SUBJECT TO LIMITATIONS AS TO THE APPROVAL OF EXPENDITURES AND AUDITS AS PRESCRIBED FOR STATE FUNDS BY THE STATE FINANCE LAW;

7. TO GATHER AND DISSEMINATE STATISTICS AND CONDUCT INVESTIGATIONS AND RESEARCH RELATING TO THE CAUSES AND PREVENTION OF TRAUMATIC BRAIN INJURIES AND THE TREATMENT OF SUCH INJURIES, INCLUDING THE METHODS AND PROCEDURES FOR REHABILITATION, INCLUDING FROM TIME TO TIME, SUCH PUBLICATIONS FOR DISTRIBUTION TO APPROPRIATE SCIENTIFIC ORGANIZATIONS;

8. TO CONTRACT WITH INDEPENDENT CONSULTANTS TO CONDUCT ASSESSMENTS OF THE NEEDS OF PERSONS WITH TRAUMATIC BRAIN INJURY;

9. TO DEVELOP TRAINING PROGRAMS FOR PERSONS PROVIDING DISCHARGE PLANS AND CASE MANAGEMENT; AND

10. TO DEVELOP STANDARDS FOR LICENSING OR CERTIFYING RESIDENTIAL AND NON-RESIDENTIAL SERVICES FOR PERSONS WITH TRAUMATIC BRAIN INJURY TO THE EXTENT THAT SUCH SERVICES ARE NOT OTHERWISE SUBJECT TO THE JURISDICTION OF ANOTHER STATE AGENCY.

S 2743. FUNDING OF TRAUMATIC BRAIN INJURY SERVICES. 1. THE DEPARTMENT

SHALL DEVELOP A BIENNIAL PLAN AND PRIORITIES FOR THE FUNDING OF SERVICES AND PROGRAMS AS AUTHORIZED BY THIS ARTICLE, WITH EMPHASIS ON THE DEVELOPMENT AND EXPANSION OF COMMUNITY-BASED SERVICES AND PROGRAMS.

2. SUCH PLAN SHALL PROVIDE FOR THE DEVELOPMENT OF SERVICES, DISPERSED GEOGRAPHICALLY TO THE EXTENT FEASIBLE, WHICH SHALL MINIMIZE THE NEED FOR OUT-OF-STATE PLACEMENTS AND PROMOTE THE RETURN OF INDIVIDUALS CURRENTLY PLACED OUT-OF-STATE TO ENHANCE FAMILY INVOLVEMENT AND PROMOTE COMMUNITY REINTEGRATION.

3. THE DEPARTMENT SHALL, TO THE EXTENT FEASIBLE, UTILIZE EXISTING ORGANIZATIONS WITH DEMONSTRATED INTEREST AND EXPERTISE IN SERVING PERSONS WITH TRAUMATIC BRAIN INJURIES AND SHALL, WITHIN FUNDS AVAILABLE, ENTER INTO CONTRACTS WITH SUCH ORGANIZATIONS.

S 2744. THE TRAUMATIC BRAIN INJURY SERVICES COORDINATING COUNCIL. 1. THE TRAUMATIC BRAIN INJURY SERVICES COORDINATING COUNCIL IS HEREBY ESTABLISHED AND SHALL CONSIST OF THE FOLLOWING PERSONS OR THEIR DESIGNEES: THE COMMISSIONER, THE COMMISSIONER OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, THE OFFICE OF MENTAL HEALTH, THE COMMISSIONER OF EDUCATION, THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, THE COMMISSIONER OF SOCIAL SERVICES, THE STATE ADVOCATE FOR THE DISABLED AND THE COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED. IN ADDITION, THE COUNCIL SHALL CONSIST OF THE FOLLOWING PERSONS: FIVE PERSONS APPOINTED BY THE GOVERNOR, THREE OF WHOM SHALL BE PERSONS WITH TRAUMATIC BRAIN INJURY AND TWO OF WHOM SHALL BE REPRESENTATIVE OF THE PUBLIC AND HAVE A DEMONSTRATED EXPERTISE AND INTEREST IN TRAUMATIC BRAIN INJURY; TWO PERSONS APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE, ONE OF WHOM SHALL BE A PERSON WITH TRAUMATIC BRAIN INJURY AND ONE OF WHOM SHALL BE REPRESENTATIVE OF THE PUBLIC AND HAVE A DEMONSTRATED EXPERTISE AND INTEREST IN TRAUMATIC BRAIN INJURY; TWO PERSONS APPOINTED BY THE SPEAKER OF THE ASSEMBLY, ONE OF WHOM SHALL BE A PERSON WITH TRAUMATIC BRAIN INJURY AND ONE OF WHOM SHALL BE REPRESENTATIVE OF THE PUBLIC AND HAVE A DEMONSTRATED EXPERTISE AND INTEREST IN TRAUMATIC BRAIN INJURY, ONE PERSON APPOINTED BY THE MINORITY LEADER OF THE SENATE WHO SHALL BE A PERSON WITH TRAUMATIC BRAIN INJURY OR BE REPRESENTATIVE OF THE PUBLIC AND HAVE A DEMONSTRATED EXPERTISE AND INTEREST IN TRAUMATIC BRAIN INJURY; AND ONE PERSON APPOINTED BY THE MINORITY LEADER OF THE ASSEMBLY WHO SHALL BE A PERSON WITH TRAUMATIC BRAIN INJURY OR BE REPRESENTATIVE OF THE PUBLIC AND HAVE A DEMONSTRATED EXPERTISE AND INTEREST IN TRAUMATIC BRAIN INJURY. OF THE FIVE PERSONS APPOINTED BY THE GOVERNOR, THREE SHALL SERVE FOR A TERM OF ONE YEAR, ONE SHALL SERVE FOR A TERM OF TWO YEARS AND ONE SHALL SERVE FOR A TERM OF THREE YEARS. OF THE TWO PERSONS APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE, ONE SHALL SERVE FOR A TERM OF TWO YEARS AND ONE SHALL SERVE FOR A TERM OF THREE YEARS. OF THE TWO PERSONS APPOINTED BY THE SPEAKER OF THE ASSEMBLY, ONE SHALL SERVE FOR A TERM OF TWO YEARS AND ONE SHALL SERVE FOR A TERM OF THREE YEARS. THE PERSON APPOINTED BY THE MINORITY LEADER OF THE SENATE AND THE PERSON APPOINTED BY THE MINORITY LEADER OF THE ASSEMBLY SHALL SERVE FOR A TERM OF ONE YEAR. SUBSEQUENT APPOINTMENTS FOR VACANCIES SHALL BE FOR A TERM OF THREE YEARS AND SHALL BE FILLED IN THE SAME MANNER AS THE ORIGINAL APPOINTMENT.

2. THE COUNCIL SHALL BE CHARGED WITH RECOMMENDING TO THE DEPARTMENT LONG RANGE OBJECTIVES, GOALS AND PRIORITIES. IT SHALL ALSO PROVIDE ADVICE ON THE PLANNING, COORDINATION AND DEVELOPMENT OF NEEDED SERVICES.

3. THE MEMBERS OF THE COUNCIL SHALL RECEIVE NO COMPENSATION FOR THEIR

SERVICES, BUT SHALL BE ALLOWED THEIR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES HEREUNDER, SUBJECT TO THE APPROVAL OF THE COMMISSIONER.

S 3. Reports. 1. On or before September 15, 1994, the department of health shall make an interim report to the governor and the legislature of the number of persons with traumatic brain injuries residing in New York state and/or those receiving treatment both in New York state and out-of-state settings. Such report shall include, but not be limited to, any other pertinent findings, conclusions and recommendations with regard to long range objectives, goals and priorities relative to the needs of persons with traumatic brain injury.

2. On or before May 1, 1995, the department of health shall make a final report to the governor and the legislature. Such report shall include, but not be limited to recommendations for:

a. the development of a uniform statewide approach to the comprehensive continuum of services to the traumatic brain injured population, with primary emphasis on community-based services and prevention;

b. the development of a coordinated linkage among various agencies, programs, consumers and any other essential providers;

c. the development of standards, policies, procedures and strategies with the primary focus on prevention and community-based services; and

d. the expected outcomes and evaluation criteria of the coordinated services provided to traumatic brain injured and their families.

S 4. This act shall take effect immediately.

The Legislature of the STATE OF NEW YORK SS: (JURAT PLACEHOLDER)

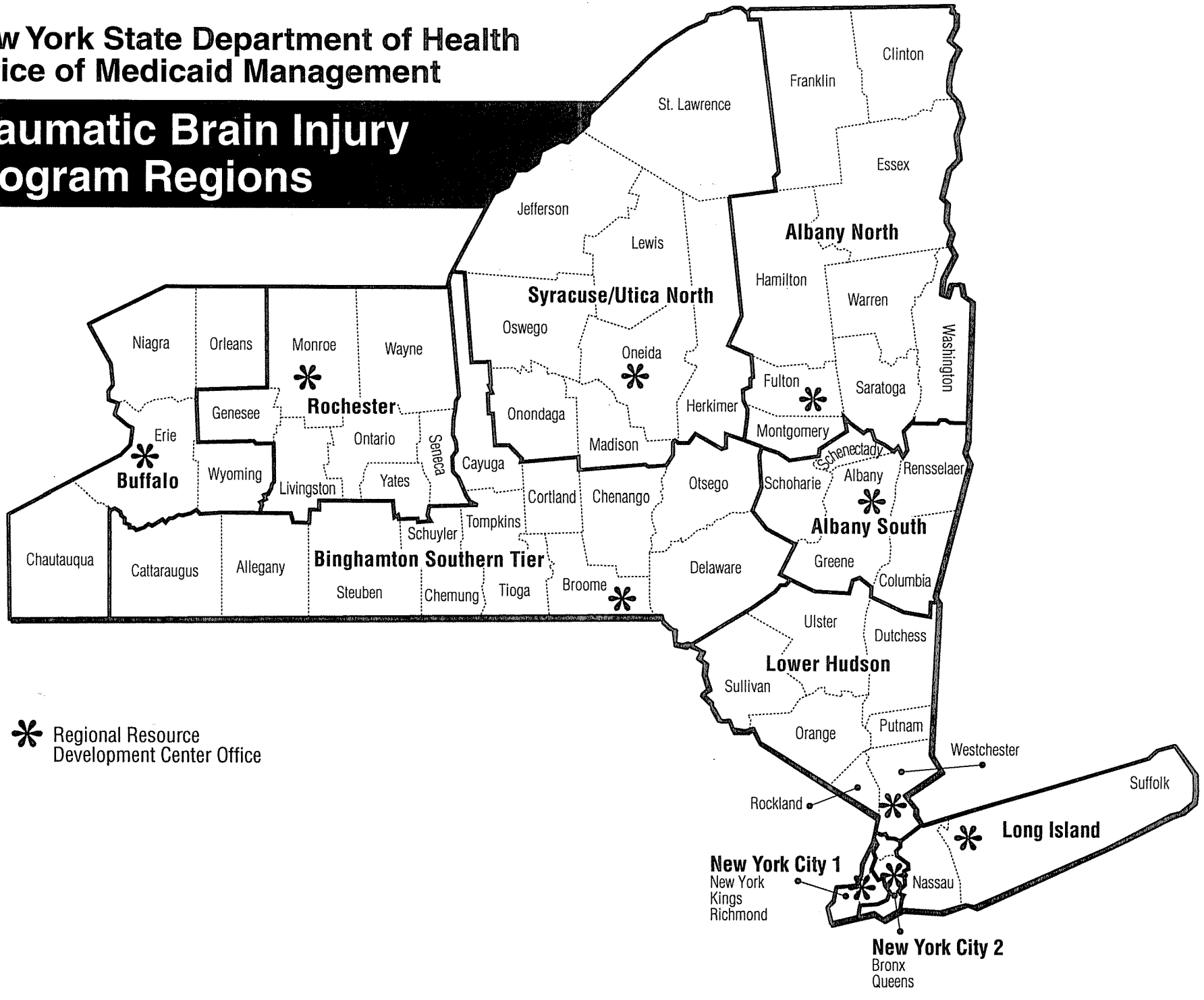
Pursuant to the authority vested in us by section 70-b of the Public Officers Law, we hereby jointly certify that this slip copy of this session law was printed under our direction and, in accordance with such section, is entitled to be read into evidence.

RALPH J. MARINO
TEMPORARY PRESIDENT OF THE SENATE

SHELDON SILVER
SPEAKER OF THE ASSEMBLY

New York State Department of Health
Office of Medicaid Management

Traumatic Brain Injury Program Regions



Regional Resource Development Center Office

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF MEDICAID MANAGEMENT

Traumatic Brain Injury Initiatives

Regional Resource Development Specialists

Counties Served	Resource Development Specialist And Phone Number	Regional Resource Center
Long Island: Nassau and Suffolk	**Bonnie Hope, RRDS** BHope@MercyHaven.com **Yolanda Lucas, Asst. RRDS** ylucas@mercyhaven.com **Margo Bosche, Admin. Asst.** MBosche@Mercyhaven.com 631-581-7100 631-581-9310 (FAX)	Mercy Advocacy Program Mercy Haven, Inc. 859 Connetquot Avenue, Suite 4 Islip Terrace, NY 11752
New York City: Boroughs of Manhattan, Brooklyn and Staten Island	**Stuart Kaufer, RRDS** SKaufer@CIDNY.org 646-442-4188 **Josephine Calder, Asst. RRDS** jcalder@CIDNY.org 646-442-4189 **Kathleen McKeon, Asst. RRDS** kmckeon@cidny.org 646-442-4151 212-254-0301 (FAX)	Center for Independence of the Disabled in New York (CIDNY) 841 Broadway, Suite 301 New York, NY 10003
New York City: Boroughs of Bronx and Queens	**Natalia Gonzalez, RRDS** NataliaG@nyc2rrdc.com **Victoria Quintero, Asst. RRDS** victoriaq@nyc2rrdc.com **Jenny Mendez, Admin. Asst.** jennym@nyc2rrdc.com 718-271-4373 718-271-9215 (FAX)	Park Terrace Center for TBI Community Re-Entry 109-40 Saultell Avenue Rego Park, NY 11368
Lower Hudson: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester	**Margaret Nunziato, RRDS** X 102 Magge914@aol.com **Lisa Howard, Asst. RRDS** X137 LHoward@wilc.org **Tamaris Princi-Morales, Asst. RRDS** X132 TPRINCI@wilc.org 914-682-3926 914-682-8518 (FAX)	Westchester Independent Living Center 200 Hamilton Avenue, 2nd Floor White Plains, NY 10601
Albany South: Albany, Schenectady, Greene, Rensselaer, Schoharie and Columbia	**Barbara McCarthy, RRDS** BMcCarthy@sunnyview.org 518-386-3555 **Maria Relyea, Asst. RRDS** MRelyea@sunnyview.org 518-386-3556 **Natalie Marabello, Asst. RRDS** nmarabello@sunnyview.org 518-386-3576 518-386-3519 (FAX)	Sunnyview Rehabilitation Hospital 1270 Belmont Avenue Schenectady, NY 12308
Albany North: Fulton, Montgomery, Saratoga, Washington, Warren, Hamilton, Essex, Franklin and Clinton	**Karen Thayer, RRDS** Kannthayer@aol.com 518-792-1584 **Joy Leiden, RRDS** joyleiden@aol.com 518-792-1585 **Lynn Osterberg, Asst. RRDS** 518-792-1584 518-792-0979 (FAX)	Glens Falls Independent Living Center 71 Glenwood Avenue Queensbury, NY 12804

yracuse/Utica North: Onondaga, ladison, Herkimer, Oneida,)swego, Lewis, Jefferson and St. awrence	**Crista Zirgulis, RRDS** czirgulis@ariseinc.org 315-671-2999 **Shannon Scott, RRDS** sscott@ariseinc.org 315-671-2980 **Denise Smith, Admin. Asst.** 315-671-2936 (FAX)	ARISE, Inc. 635 James Street Syracuse, NY 13203
Binghamton Southern Tier Region: Broome, Steuben, Schuyler, Tioga, Delaware, Tompkins, Cortland, Chenango, Cayuga, Chemung, Cattaraugus, Allegany and Otsego	**Rhonda Bennett, Clinical Consultant** **Beth Hall, RRDS** **Al Jennings, RRDS** **Laura O'Hara, Asst. RRDS** tbiresource@stic-cil.org tbiconsult@stic-cil.org (Rhonda Only–CC) 607-724-2111 607-772-3609 (FAX)	Southern Tier Independence Center 24 Prospect Avenue Binghamton, NY 13901
Rochester Region: Monroe, Wayne, Ontario, Seneca, Genesee, Livingston and Yates	**Kate Aghaghiri, RRDS** kaghaghiri@unityhealth.org 585-368-3764 **Terri Mercado, RRDS** tmercado@unityhealth.org 585-368-3833 **Clare Stortini, Asst. RRDS** cstortini@unityhealth.org 585-368-3364 585-368-3765 (FAX)	Unity St. Mary's Campus Brain Injury, Pediatric & General Rehab Programs 89 Genesee Street Rochester, NY 14611
Buffalo Region: Erie, Chautauqua, Wyoming, Orleans and Niagara	**Ronald Fernandez, RRDS** **David Giordano, RRDS** TBI_RRDC@headwayofwny.org 716-629-3633 716-882-1289 (FAX)	Headway of Western NY, Inc. 976 Delaware Avenue, Lower Level Buffalo, NY 14209

Statewide:

NYS DOH TBI Program Staff	**Patricia Greene Gumson** (RRDS/Waiver) Prg01@health.state.ny.us **Shirley Gnacik** (Housing) Shg02@health.state.ny.us **Helen Callahan** (Contracts, Vouchers, Fair Hearings) Hmc04@health.state.ny.us **Janette Biggs** (Housing, Provider Enrollment, MA Billing) Jlb01@health.state.ny.us **Laurie Arcuri** Laa03@health.state.ny.us **Jeanette Santos** Jxs15@health.state.ny.us **Laura Roe**, Administrative Asst. Lar04@health.state.ny.us	NYS Department of Health Bureau of Long Term Care TBI Program One Commerce Plaza, Room 826 Albany, NY 12260 518-474-6580 518-474-7067 (FAX)
Southern Tier Independence Center Statewide Neurobehavioral Resource Project	**Tim Feeney, Ph.D.** tfeeney@scssconsulting.com **Melissa Capo** mcapo@scssconsulting.com 518-372-2026 518-372-2028 (FAX) **Paul Akers** pauldakers@yahoo.com 585-334-9070 585-334-7094 (FAX) (Referrals)	600 Franklin Street, Suite 110 Schenectady, NY 12305 73 Parkerhouse Road Rochester, NY 14623
TBI Housing Resource	**Anne Mullaney,** annemu@cucs.org 212-801-3334 **Renee Bueller,** rbueller@cucs.org 212-801-3312 **Roni Rodman,** rrodman@cucs.org 212-801-3330 **Denise Brown,** dbrown@cucs.org 212-801-3340 212-801-3360 (FAX)	Center for Urban Community Services (CUCS) 120 Wall Street, 25th Floor New York, NY 10005

NEW YORK STATE DEPARTMENT OF HEALTH
WAIVER PARTICIPANT CONTRACT
FOR RENTAL SUBSIDY

Rev. 11/05

This contract must be reviewed with the waiver participant and signed when: (a) initially applying for a housing subsidy; (b) annually at the time of lease renewal; and (c) anytime there is a change in address or amount of rental subsidy.

Individuals in the Traumatic Brain Injury (TBI) waiver who are receiving a rental subsidy from the TBI Housing Program must agree to all of the conditions below. **Failure to comply with the terms of this contract may result in a decrease in the TBI rental subsidy and/or termination from the TBI Housing Program.**

In order to be eligible for the TBI Housing Program and to continue to receive a rental subsidy I understand that:

1. I must be a participant in the TBI waiver.
2. I must participate in my services as described in my Service Plan.
3. I must be receiving Medicaid and I must make sure that any "spend down" requirements to maintain my Medicaid are met each month.
4. I must apply for a Section 8 HUD rental subsidy and maintain an active application. If HUD housing becomes available, I am required to accept it and discontinue the TBI Housing Program rental subsidy.
5. I must provide my Service Coordinator with all information regarding my finances including but not limited to my total monthly income, savings, supplemental needs trust, and awards from SSI and/or SSDI. I must inform my Service Coordinator immediately of any changes to my finances.
6. I must pay one third (1/3) of my total monthly income (after spend down) towards my rent. If my monthly income increases, I understand that the amount I pay towards rent each month will also increase. Income received from SSI, DSS, SSDI and/or child support for minor children living with me is included in my monthly income.
7. I must pay my portion of the rent on time each month. Failure to pay on time may result in a reduction in my rent subsidy or termination from the TBI Housing Program.

Waiver Participant _____

Advocate/Guardian _____

Service Coordinator _____

NEW YORK STATE DEPARTMENT OF HEALTH
WAIVER PARTICIPANT CONTRACT
FOR RENTAL SUBSIDY

Rev. 11/05

8. I may NOT withhold my portion of the rent for any reason. Any problems with the landlord or apartment should be discussed with my Service Coordinator.

9. If anyone moves into my apartment who is not a waiver participant, they are responsible for one half of all rental and utility expenses and my TBI rental subsidy will be reduced accordingly. If the other individual does not pay their portion of the expenses I risk the loss of my TBI rental subsidy and termination from the TBI Housing Program.

10. I must abide by all agreements of the lease.

11. I must not engage in unlawful activities in my apartment or common areas. This includes, but is not limited to, the possession and/or sale of illegal drugs and disturbances or acts of violence that damage or destroy the dwelling unit or disturb or injure other residents.

12. I must not permit my guests to engage in unlawful activities in the apartment or the common areas.

13. I must not cause disruption in the building or be disrespectful to my fellow tenants.

14. I must pay for all repairs to the apartment or appliances, which are due to damages that I caused.

15. When I move out, I must remove all personal property and trash from the premises and return the keys to the landlord.

16. If DOH has paid for my security deposit and if some or all of the deposit is not refunded due to my actions or neglect, I understand that my future rental subsidy may be decreased or terminated until the expense has been recouped.

17. I must not make any changes to the structure of the apartment without obtaining written permission from my landlord and consulting with my Service Coordinator.

18. If I share the apartment with another TBI waiver participant, the furnishings purchased by the TBI Housing Program for common living areas belong to both tenants equally. If one participant moves out, an agreement must be reached on how to distribute the furnishings.

19. Each TBI wavier participant shall have the right of complete privacy in his or her own bedroom.

Waiver Participant _____

Advocate/Guardian _____

Service Coordinator _____

NEW YORK STATE DEPARTMENT OF HEALTH
WAIVER PARTICIPANT CONTRACT
FOR RENTAL SUBSIDY

Rev. 11/05

20. I am responsible for maintaining any furniture purchased for my residence with money from the Department of Health. Damaged and ruined furniture will not be replaced.

21. I must report any needed repairs in my apartment to my Service Coordinator.

22. I must not leave anything in or on the fire escapes, sidewalks, entrances, exits, driveways, elevators, stairways, or halls.

23. If for any reason the TBI Housing Program pays any part of my portion of the rent, my rental subsidy will be decreased and the amount I owe the landlord will be increased each month until all money has been refunded to the TBI Housing Program.

24. I must inform my Service Coordinator BEFORE I sign a lease renewal. I understand that the TBI Housing Program will only be responsible for one year leases.

25. In order for my rental subsidy to continue, I must permit a visit from my Service Coordinator and/or the Housing Locator agency at least annually to complete a Housing Standards Checklist.

I have read the TBI Housing Contract. I understand and agree to all the terms and conditions as stated. I understand that violations of any of these conditions may result in a decrease in my rental subsidy or termination from the TBI Housing Program. I accept the terms of this contract and the Housing Support and Rental Subsidy Application.

Waiver Participant _____ Date _____

Advocate/Guardian _____ Date _____

Service Coordinator _____ Date _____

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF MEDICAID MANAGEMENT

Traumatic Brain Injury Initiatives

Home and Community-Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury

The Home and Community-Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury (HCBS/TBI) is one component of a comprehensive strategy developed by the New York State Department of Health to assure that New Yorkers with a traumatic brain injury could receive services within New York in the least restrictive setting.

Philosophy

The HCBS/TBI waiver was developed based on the philosophy that:

- An individual with a TBI has the same right to be in control of his or her life as anyone else in our society.
- An individual with a TBI must be able to choose where he or she wants to live, with whom he or she will live and who will provide any needed services.
- An individual with a TBI has the right to learn as a member of society, by encountering and managing risks and, through experience, learn from related failures.

What is a HCBS Medicaid Waiver?

- Medicaid has an institutional bias providing comprehensive services only on an inpatient basis; a waiver is an opportunity for comprehensive services to be available in the community.
- A HCBS waiver allows states to assemble a package of carefully tailored services to comprehensively meet the needs of a targeted group in a community-based setting.
- A state must assure, through an individualized service plan, the waiver participant's health and welfare.
- A state must assure that the overall cost of serving the waiver participants in the community is less than the cost of serving this same group in an institution.

Why did New York State Develop the HCBS/TBI Medicaid Waiver?

- In the 1970's and 80's New York was sending individuals with TBI to out-of-state nursing homes. By the late 1980's, 500 people were in those facilities at a cost to Medicaid of $56 million.
- The HCBS/TBI waiver provides a cost-effective community-based alternative to nursing facility care.
- Individuals with TBI and their families advocated for community-based services and supports.
- Institutional care prevents an individual with a TBI from becoming reintegrated into his/her home community.

Expected Outcomes from the HCBS/TBI Waiver

- Individuals with TBI will be able to choose where and with whom they live.
- Individuals with TBI will be able to live self-satisfying lives.
- With a decrease in reliance on expensive nursing facility care, the State Medicaid program will realize significant savings.

To be Eligible for the HCBS/TBI Waiver an Individual Must:

- Have a diagnosis of TBI or a related diagnosis
- Be eligible for nursing facility level of care as determined by a Patient Review Instrument (PRI) and SCREEN
- Be enrolled in the Medicaid Program
- Be 18-64 years old
- Choose to in the community rather than a nursing facility
- Have or find a living arrangement which meets the individual's needs
- Be able to be served with the funds and services available under the HCBS/TBI waiver and New York State Medicaid State Plan

Regional Resource Development Centers (RRDC)

The HCBS/TBI waiver is administered through a network of RRDCs, each covering specific counties throughout the State. The contact person at the RRDC is the Regional Resource Development Specialist (RRDS).

The RRDS is responsible for:

- Interviewing potential waiver participants
- Assisting participants to access approved providers
- Approving Service Plans
- Reviewing Incident Reports
- Maintaining regional budgets for waiver services

Source of Supports and Services for Waiver Participants

Informal Supports

- Family
- Friends
- Community

Other State and Federally Funded Services

- VESID
- HEAP
- Housing subsidies/subsidized housing
- Education benefits
- Mental health
- Substance abuse services
- Other

Medicaid State Plan Services and Supports

- Clinic
- Physician/dentist
- Hospital
- Therapies
- Home health – including personal care
- Pharmaceuticals
- Medical transportation
- Medical supplies and equipment
- Eyeglasses
- Hearing aids
- Consumer Directed Personal Assistance Program
- Other

HCBS/TBI Waiver Services

- Service coordination
- Independent living skills training and development
- Structured day program
- Substance abuse programs
- Intensive behavioral programs
- Community integration counseling
- Home and community support services
- Environmental modifications
- Respite care
- Assistive Technology
- Transportation
- Community Transition Services

HCBS/TBI Waiver Services

1. Service Coordination

The key to individual choice and satisfaction is person-centered service coordination. The Service Coordinator:

- Is responsive to the individual and helps the waiver participant identify his or her unique needs;
- Promotes activities which will increase the individual's independence and life satisfaction;
- Assists in the integration of the individual in the community of his/her choice;
- Helps in increasing the individual's productivity and participation in meaningful activities; and
- Assists in arranging for daily living supports and services to meet the individual's needs.

2. Independent Living Skills Training and Development

Improves and maintains the individual's community living skills so that the individual can live as independently as possible. This will be done primarily in one-on-one training, and focuses on practical needs such as shopping, cooking, money management, use of public transportation, etc. This service is provided in the individual's residence and in the community.

3. Structured Day Programs

Improves and maintains the individual's community living skills in a congregate non-residential, non-medical setting. The focus will be on the development of social, problem-solving and task-oriented skills.

4. Substance Abuse Programs

Reduces and/or eliminates substance abuse which may interfere with the individual's ability to be maintained in the community. This service will be specifically designed to meet the needs of individuals with cognitive deficits, and will work with existing community support systems, such as AA or Al-Anon, to assist them in becoming more responsive to people with traumatic brain injuries.

5. Intensive Behavioral Programs

Eliminates and/or reduces an individual's severe maladaptive behavior(s) which, if not modified, will interfere with the individual's ability to remain in the community. These services are provided in the individual's residence and in the community and are provided by a highly trained team to an individual, his/her family, or anyone else having significant contact with the individual.

6. Community Integration Counseling

Assists the waiver participant, family members and significant informal supports to adjust to challenges of living with a traumatic brain injury.

7. Home and Community Support Services

Assists the individual to live in the community with needed support including safety monitoring, assistance with activities of daily living and integration into the community. These services can be provided in the individual's residence or in the community.

8. Environmental Modifications
Provide for physical adaptations to the individual's residence and primary vehicle which ensure the individual's health, safety and welfare and which increase the individual's independence and integration in the community.

9. Respite Care
Provides short-term relief for informal caregivers of individuals who are unable to care for themselves. This service will be provided primarily in the individual's residence.

10. Assistive Technology
Provides durable and non-durable medical equipment not usually funded under the Medicaid State Plan. An example of the equipment available through this service is a three wheel cart for mobility purposes.

11. Social Transportation
Provides the means to access non-medical services in the community in order to improve the individual's ability to make use of needed services, and to improve the individual's integration in the community.

12. Community Transition Services
Assists individuals leaving nursing homes by providing assistance with payment of a Security deposit , utility set up fees, moving expenses, purchase of essential furniture, and initial cleaning service. This service has a budget cap.

Room and Board
The federal government does not allow funds provided under any Medicaid waiver to be used for housing or food. These necessities must be paid for through other funds including:

- Family or personal funds
- SSI/SSDI
- Subsidized housing
- HCBS/TBI waiver housing funds
- Food Stamps

The Use of a Regional Aggregate Budgeting System

The HCBS/TBI waiver will use a regional aggregate cap in determining the amount of funds available for waiver services. This will:

- Provide the opportunity to serve individuals with greater needs
- Assure that the maximum benefits possible under the waiver will be realized
- Allow for maximum creativity and innovation
- Increase flexibility to accommodate an individual's short term needs

For further information contact the New York State Traumatic Brain Injury Waiver at (518) 474-6580

NEW YORK STATE DEPARTMENT OF HEALTH

OFFICE OF MEDICAID MANAGEMENT

Traumatic Brain Injury Initiatives

Home and Community-Based Services

Medicaid Waiver for Individuals with

Traumatic Brain Injury

PROGRAM MANUAL

(June 2006)

Excerpts

TABLE OF CONTENTS

Included

Section I

Introduction and Philosophy of the HCBS/TBI Waiver

The Program Manual

The Home and Community Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury (HCBS/TBI) began providing services in April 1995. The original Program Manual was created to provide guidelines about the processes and services associated with this innovative program.

Since its inception, the waiver has remained flexible and responsive to the needs of participants and providers. This revised Program Manual reflects these changes and provides further clarification of definitions and scope of the HCBS/TBI waiver services.

The revised Program Manual is dedicated to all participants of the past, present and future, and to those individuals who have assisted people with brain injuries to be in control of their lives and to live as independently as possible in the community.

Introduction to the HCBS/TBI Waiver

The HCBS/TBI waiver is administered by the New York State Department of Health (DOH) through the Regional Resource Development Centers (RRDC) and Specialists (RRDS) who serve specific counties throughout the State.

The waiver uses Medicaid funding to provide supports and services to assist an individual with a traumatic brain injury (TBI) toward successful inclusion in the community. Waiver participants may come from a nursing facility or choose to participate in the waiver to prevent institutionalization.

Waiver services may be considered when informal supports, local, State and federally funded services, and Medicaid State Plan services are not sufficient to assure the health and welfare of the individual in the community.

Philosophy of the HCBS/TBI Waiver

The dignity of risk and right to fail are integral parts of the waiver's philosophy. The philosophy of the waiver supports the participant's right to choose where to live, who to live and socialize with, and what goals and activities to pursue.

Waiver services are provided based on the participant's unique strengths, needs, choices and goals. The individual is the primary decision-maker and works in cooperation with providers to develop a plan for services. This process leads to personal empowerment, increased independence, greater community inclusion, self-reliance and meaningful and productive activities.

Section II

Becoming a Waiver Participant

Eligibility Criteria

An individual applying to participte in the waiver must meet all of the following criteria:

1. Be a Medicaid recipient.

2. Have a diagnosis of traumatic brain injury (TBI).
   NOTE: Individuals who experience deficits similar to a traumatic brain injury as a result of anoxia, toxic poisoning, stroke or other neurological conditions may also be eligible. Individuals with gestational or birth difficulties such as cerebral palsy or autism or who have a degenerative disease, are not eligible for the waiver.

3. Be between the ages of 18 and 64 upon application to the waiver.

4. Be assessed to need a nursing home level of care as a direct result of the traumatic brain injury. Nursing home eligibility is determined by the Hospital and Community Patient Review Instrument and SCREEN (PRI/SCREEN). The form must be dated within three months of the individual's application to the waiver and be completed by an individual certified to use the tool (Appendix C-1).

5. Choose to participate in the waiver rather than reside in a nursing facility by signing the Freedom of Choice form, Application for Participation form and Service Coordination Selection form (Appendix B-1).

6. Identify the residence in which the waiver participant will be living when receiving waiver services.

7. Complete an Initial Service Plan and Application Packet (Appendix C-1) in cooperation with a Service Coordinator and approved by the RRDS. This Plan must describe why the individual is at risk for nursing home placement without the services of the waiver and indicate how the available supports and requested waiver services identified in the Plan will support the health and welfare of the potential participant.

8. Have a completed Plan for Protective Oversight (PPO) (Appendix C-1).

Steps to Becoming a Waiver Participant

The following steps describe the application process for becoming a waiver participant:

STEP 1 Potential participant contacts the RRDS in the region where they choose to reside.

STEP 2 The RRDS describes the waiver philosophy and available services to the potential participant and makes a preliminary determination of probable eligibility for the waiver.

STEP 3 The RRDS provides the potential participant with a list of approved Service

Coordination providers and encourages him/her to interview potential Service Coordinators.

STEP 4 The potential participant selects a Service Coordination Agency from the list of approved providers, completes the Service Coordinator Selection Form (Appendix B-1) and returns it to the RRDS.

STEP 5 The RRDS forwards the Service Coordinator Selection form (Appendix B-1) to the selected provider for their signature, indicating that they are willing and able to accept the applicant.

STEP 6 The applicant and anyone he/she may choose, work with the Service Coordinator to develop an Initial Service Plan and complete the Application Packet.

STEP 7 The Service Coordinator sends the completed Application Packet to the RRDS (see Section V – The Service Plan).

STEP 8 The RRDS reviews the Application Packet and either approves the Packet or requests, in writing, revisions and/or additional information needed for approval.

STEP 9 A Notice of Decision Authorization/Reauthorization is issued by the RRDS for the approved Application Packet. The Notice of Decision indicates the start and end dates for the initial six-month approval period. Subsequent six-month approvals are based on the participant's choice to remain in the waiver, ongoing eligibility, and completion of an approved Revised Service Plan.

STEP 10 A Notice of Denial is issued when the RRDS determines that the individual is not eligible for the waiver or the Service Plan does not describe a sufficient level of supports and/or services to maintain the individual's health and welfare.

NOTE: When a participant chooses to relocate to a region covered by another RRDS, the current RRDS is responsible for making the initial contact with the RRDS in the relocation region. The RRDS from the new region will contact the individual to provide the list of approved Service Coordination providers in that region.

Notice of Decision for Denial or Discontinuation of Waiver Services

A Notice of Denial is sent when an individual is not eligible to receive waiver services for the following reasons:

(1) The participant chooses not to receive waiver services.

(2) The participant is:

- Not Medicaid eligible;
- Not assessed to a nursing home level of care based on the PRI/SCREEN; or
- Not capable of living in the community with the assistance of informal supports, non-Medicaid supports, State Plan Medicaid services, and/or waiver services.

(3) The services and supports available through the waiver and all other sources are not sufficient to maintain the individual's health and welfare in the community.

(4) The participant chooses to receive services from another Home and Community Based Services Medicaid Waiver.

(5) The cost of the Service Plan is above the level necessary to meet the federally mandated requirement that waiver services must be cost neutral in the aggregate when compared to Statewide nursing home costs.

A Notice of Discontinuation will be sent to the participant when any of the following occur:

a. The participant is hospitalized for more than 30 days and there is no scheduled discharge date;
b. The participant is admitted to a nursing home, psychiatric facility or other institution for other than a short term; or
c. The participant is incarcerated for more than 30 days.

Fair Hearings/Administrative Meeting

Introduction

Individuals receiving a Notice of Decision (NOD) for issues related to the waiver are eligible for a fair hearing and, in some instances, may request aid to continue. All NODs must include information regarding an individual's fair hearing rights.

Fair Hearings

An individual has the right to seek a Medicaid Fair Hearing for many reasons including issues related to the HCBS/TBI waiver. Decisions regarding Medicaid eligibility are addressed through the fair hearing process with the local Department of Social Services.

Administrative Meeting

If a participant receives any Notice of Decision from the RRDS, an Administrative Meeting may be conducted prior to pursuing a formal Medicaid Fair Hearing. A review by the RRDS may be requested by the participant, an advocate, Service Coordinator or anyone involved in the development of the Service Plan.

This review is an opportunity for the participant and advocates to review with the RRDS the reasons for the NOD and address information they feel is not properly represented. Through discussion and negotiation, it may be possible to resolve issues without a Medicaid Fair Hearing.

Issues about the waiver that are addressed through the Medicaid Fair Hearing process include:

(1) Was the applicant offered the choice of waiver service(s) as an alternative to a nursing home;

(2) Was the applicant or participant denied the service(s) of his or her choice;

(3) Was the applicant or participant denied the services of a qualified provider that was willing to serve the applicant or participant;

(4) Was the decision of denial or discontinuance of waiver services correct; and

(5) Was the decision to reduce or eliminate waiver services correct.

Issues about the waiver that are NOT addressed through the Medicaid Fair Hearing process include:

(1) Was the applicant or participant in need of a nursing home level of care (as determined by the PRI/SCREEN);

(2) Does the waiver have any openings based on the number of participants approved for the waiver as specified by the federal government; and

(3) Does the applicant have a traumatic brain injury (TBI) as defined by the waiver.

Waiver Participants Rights and Responsibilities

A waiver participant is assured certain rights, and must agree to certain responsibilities related to the waiver program.

The Service Coordinator is responsible for explaining to the waiver applicant/participant, the rights and responsibilities of being a waiver participant. These rights and responsibilities should be reviewed with the participant at least annually, and any time the Service Coordinator is aware that the participant does not understand his/her rights or responsibilities.

The Waiver Participant's Rights and Responsibilities (Appendix C-1) must be signed and dated by the applicant. The original document is included in the Application Packet. A copy is given to the participant to be maintained in an accessible location in the participant's home.

As a Waiver Participant You Have The Right To:

1. Be informed of your rights prior to receiving waiver services;
2. Receive services without regard to race, color, creed, gender, national origin, sexual orientation or disability;
3. Be treated as an individual with consideration and respect;
4. Have services provided that support your health and welfare;
5. Assume reasonable risks and have the opportunity to learn from these experiences;
6. Be provided with an explanation of all services available in the HCBS waiver and other health and community resources that may benefit you;
7. Have the opportunity to develop, review and approve all Service Plans, including any changes to the Service Plan;
8. Select individual service providers and choose to receive additional waiver services from different agencies or different providers within the same agency without jeopardizing participation in the waiver;
9. Request a change in services (increase, decrease or discontinuation) at any time;
10. Be informed of the name and duties of any person providing services to you under your Service Plan;

11. Have input into when and how waiver services will be provided;

12. Receive services from approved, qualified individuals;

13. Receive from the Service Coordinator a list of telephone numbers and supervisors for all service providers, the RRDS and DOH;

14. Refuse care, treatment and services after being fully informed of and understanding the consequences of such actions;

15. Have your privacy respected, including the confidentiality of your personal records, and have the right to refuse the release of the information to anyone not authorized to have such records, except in the case of your transfer to a health care facility or as required by law or Medicaid requirements;

16. Submit complaints about any violation of rights and any concerns regarding services provided, without jeopardizing your participation in the waiver;

17. Receive support and direction from the Service Coordinator to resolve your concerns and complaints about services and service providers;

18. Receive additional support and direction from the RRDS and DOH in the event that your Service Coordinator is not successful in resolving your concerns and complaints about services and service providers;

19. Have your complaints responded to and be informed of the resolution;

20. Have your service providers protect and promote your ability to exercise all rights identified in this document; and

21. Have all rights and responsibilities outlined in this document forwarded to the committee or legal guardian authorized to act on your behalf.

Waiver Participant's Responsibilities

As a participant you are responsible for:

1. Working with your Service Coordinator to develop/revise your Service Plan to assure timely reauthorization of the Service Plan;

2. Working with waiver providers as described in your Service Plan;

3. Talking to your Service Coordinator and other waiver providers if you want to change your goals or services;

4. Not participating in any criminal behavior. You understand that, if you do, your service provider(s) may leave, the police may be called and your continuation in the waiver program may be jeopardized.

5. Maintaining your home in a manner which enables you to live in the community.

6. Complying with the terms and conditions of any contract you sign regarding the provision of waiver services.

Section V

The Service Plan

Development of the Service Plan

An individualized Service Plan is developed by the participant, the Service Coordinator and, when necessary, a court appointed guardian. The participant may choose to include family, friends and advocates.

The Service Plan must reflect the participant's strengths and abilities. It details the services necessary to maintain the participant in the community and prevent institutionalization while allowing for dignity to risk and the right to fail. It specifies all supports to be provided to the participant, including: informal caregivers (i.e. family, friends); local, state and federally funded services; Medicaid State Plan services; and waiver services.

The Service Plan must reflect coordination between all providers involved with the participant. It is necessary to obtain input from agencies other than waiver providers that authorize and/or directly provide needed services. Some Medicaid funded services such as personal care services (known as home attendant services in New York City) require prior approval from the local Social Services District or, in some counties, the Community Alternative Services Agency (CASA).

Service Plans are expected to evolve as the participant experiences life in the community, requests revisions, experiences significant life changes, or as new service options become available.

Scheduling of Waiver Services

The Service Plan must include a one week schedule indicating the name of each provider and the day(s), time(s), and frequency of each service using the form in the Service Plan. The schedule should be flexible to allow for preferences and limitations of the participant, such as a limited attention span or reduced stamina. It should be designed to meet the goals and needs of the participant, support the waiver's philosophy of choice, and provide for the health and welfare of the participant.

The Service Plan must document any situations where two services must be provided at the same time to ensure consistent and effective service provision. Such situations must be clinically justified and time limited. Examples: (1) When an Independent Living Skills Training (ILST) provider is training Home and Community Support Services (HCSS) provider to assist a participant in a specific task, or when the Director of the Intensive Behavioral Program (IBP) must observe a participant's behavior at the Structured Day Program (SDP). The overlap of services must be documented in the Service Plan in order for both services to be reimbursed. (2) Inclusion of HCSS services to be used when the participant will be absent from a service and requires supervision, such as if the participant chooses not to attend SDP but needs supervision to assure health and welfare.

Services may be rescheduled if the participant is unable to participate or the provider is not available. When the provider requests that a service be suspended for a day or more, it is the responsibility of the participant or the Service Coordinator to notify the providers. If the participant notifies the providers, he/she must also notify the Service Coordinator.

A provider should notify the Service Coordinator when a participant repeatedly refuses a service. The Service Coordinator should review the Service Plan with the participant to determine if it needs to be revised to more accurately reflect the goals and abilities of the participant. Revisions to the schedule should allow enough time for the provider to make the necessary arrangements. When a participant refuses all waiver services, it may be necessary to discontinue the individual from the waiver.

The participant and anyone who contributes to the development of the Service Plan must review and sign the written Plan before the Service Coordinator submits it to the RRDS for review.

Types of Service Plans

The following is an explanation of the different types of Service Plans.

1. **Initial Service Plan (ISP) – Due to the RRDC within 60 calendar days from Service Coordinator selection**

The ISP is used when an individual is applying to become a waiver participant. It is the primary component of the Application Packet (see Section II).

The ISP contains an assessment of the individual's strengths, limitations, and goals. It identifies what services are necessary to maintain the individual in the community. For a potential participant presently in an institution, the ISP must include current summaries of all services provided and a discharge summary from the facility, including relevant medical reports and assessments.

The Service Coordinator must provide a detailed explanation of the potential participant's choices and needs, including information regarding relationships, desired living situation, recreation or community inclusion time activities, physical and mental strengths or limitations, spiritual needs and goals for vocational training, employment or community service. A description about why the waiver services are needed to prevent placement in a nursing home is also included. The ISP is approved for six (6) months.

In addition to the information requested in the ISP, the following documentation must be submitted with the Application Packet:

- A PRI/SCREEN completed within the six months prior to application;
- Medical documentation of a brain injury;
- A completed Application for Participation form;
- A completed Freedom of Choice form;
- A completed Service Coordinator Selection form;
- A signed Participants' Rights and Responsibilities form;
- A completed Plan for Protective Oversight (PPO); and
- A completed Housing Standards Checklist for participants receiving a TBI Housing subsidy.

2. **Revised Service Plan (RSP)**

The RSP is required in following situations:

- At least every six months if the participant chooses to continue waiver services;
- When a participant has been institutionalized or hospitalized for an extended period; or
- Any time there is a need for a significant change in the level or amount of services (e.g. a decrease/increase in the participant's abilities or a change in the participant's living situation).

The RSP must contain a review of the participant's previous six months in the waiver and identify the plans and goals for the next six months. It identifies how waiver services continue to prevent institutionalization and specifies the services necessary to maintain the participant health and welfare in the community.

The Service Coordinator develops the RSP using information from Individual Service Reports submitted by each waiver service provider. Each Report contains a detailed description of the type and frequency of services provided, outcomes and accomplished goals. The Report identifies specific reasons for continuing the service at the present frequency, changing the frequency and/or duration of the service or terminating the service.

The Service Coordinator must discuss any proposed changes to the Service Plan with the participant and the individual(s) who participated in the development of the Plan. Once the participant and individual(s) agree to the Plan, they are required to sign the Plan prior to submitting to the RRDS for approval.

The RRDS will notify the Service Coordinator in writing of any areas of the Plan that need further clarification or will send a Notice of Decision including the start and end dates for the next six month approval period.

The RSP must include:

- PRI/SCREEN, if due;
- ISRs from all providers; and
- An updated PPO.

3. Addendum to the Service Plan

The Addendum to the Service Plan is needed when there is an existing Notice of Decision and only a minor change is needed in the amount, type, or mix of waiver services (e.g. a participant wishes to increase/decrease the amount of time at a Structured Day Program).

When an Addendum to the Service Plan is approved, a new Notice of Decision will **not** be issued and the six month approval period on the current Notice of Decision remains in effect.

The waiver is a prior approval program. No services can be provided without

written prior approval from the RRDS. Services provided without RRDS approval are not eligible for reimbursement.

The Plan for Protective Oversight (PPO)

The PPO indicates all activities that directly impact the health and welfare of the participant and clearly identifies the individual(s) responsible for providing the assistance. The PPO must be included with an ISP, RSP and Addendum. Any PPO must be signed and dated by all the individuals listed as supports to the waiver participant.

Approval Process for Service Plans

It is recommended that the Service Coordinator have another Service Coordinator or supervisor review a completed Plan prior to submission to the RRDS for approval. This provides a professional objective review which will identify any inconsistencies or problems in the Plan which could impede the approval process.

The approval process is the same for all Service Plans. The RRDS reviews the Service Plan to determine:

1. Is the individual eligible for waiver services;
2. Is there a completed and reasonable PPO;
3. Is the PRI/SCREEN submitted, if necessary, and does it justify the need for nursing home level of care;
4. Is the current Service Plan reasonable given the context the participant's stated goals;
5. Are waiver services being used in a reasonable and effective manner;
6. Do the services described in the Plan assure the individual's health and welfare;
7. Have the goals and preferences described in previous Service Plans been the focus of the activities in the last six months;
8. If overall Plan and goals for each waiver describe the activities that each service will provide towards the accomplishment of the participant's goals; and
9. That all informal and non-waiver services are utilized wherever appropriate.

The Service Coordinator is responsible for ensuring that all service providers receive a copy of the approved Service Plan and are aware of the overall plan and goals.

Ongoing Review of the Service Plan

The Service Coordinator should regularly review the Plan with the participant. This review is a natural component of the meetings between the participant and Service Coordinator.

A formal review must be conducted when a RSP is due. Other events which may trigger a review include:

- The participant requests a change in services or service providers;
- There are significant changes in the participant's physical, cognitive, or behavioral status;

- A new provider is approved and the participant is interested in either changing providers or adding a newly available service; and
- The expected outcomes of the services are either realized or need to be altered.

The review should focus on all aspects of the participant's life, including:

- Satisfaction with the performance of providers and informal supports;
- Satisfaction with the living situation;
- Adequacy of supports and services;
- Sufficient opportunities to participate in community activities;
- Achievement of goals related to waiver services;
- Changes in functioning and/or behavior; and
- Changes in priorities or goals.

Timeliness of Service Plan Submission

Late submission of a Service Plan can result in the interruption of services to a participant and penalties to the provider agency. Required timeframes and potential penalties are described below.

Submission of the Application Packet and Initial Service Plan

Once the potential participant selects a Service Coordinator, the Service Coordinator has **sixty (60) calendar days** to submit a completed Application Packet, including the ISP, to the RRDS.

If a delay is expected in submitting an Application Packet, the Service Coordinator must notify the RRDS to receive technical assistance. The RRDS may choose to grant a brief extension of the sixty day deadline.

After sixty days, the Service Coordinator will receive written notification from the RRDS indicating that the Application Packet is due.

If the Packet is not received within the next **thirty (30) calendar days,** the RRDS will send a second notice to the Service Coordinator stating that the RRDS will meet with the potential participant to select another Service Coordinator.

When late submission of Application Packets becomes a repeated problem, the RRDS will notify the provider of removal from the list of potential Service Coordinators until a written Plan of Correction is submitted and approved. If this problem is not corrected, DOH will terminate the Provider Agreement.

Submission of Revised Service Plans

It is essential that all RSP be submitted prior to the end of the six month approval period to prevent delays in service which would negatively impact the health and welfare of the participant.

The RRDS will send notices to the Service Coordinator when a RSP is due:

1. A notice is sent to the Service Coordinator and his/her supervisor two weeks after the end of the current approval period. It will state that:

    - The Service Coordinator must submit an acceptable RSP within ten (10) working days; and
    - If an acceptable RSP has not been received within the ten (10) working days, the provider will be unable to provide initial Service Coordination for other participants until an acceptable RSP for the participant has been received.

2. If an acceptable RSP is not received within thirty (30) calendar days of this notice DOH will send a letter to the provider and begin the sixty (60) day disenrollment process in accordance with the Provider Agreement. To stop the disenrollment process, an acceptable RSP and a Plan of Correction must be submitted to the RRDS. DOH, in consultation with the RRDS, will determine if the disenrollment process should continue.

When late submission of RSP becomes a repeated problem, DOH and the RRDS may limit referrals or initiate disenrollment of the provider.

Delinquent Individual Service Reports from Waiver Providers

Individual Service Reports (ISR) are required by the Service Coordinator for the development of the RSP. The Service Coordinator is responsible for informing the waiver service providers that the ISR are due.

When a provider is repeatedly or significantly delinquent in submitting ISR, the Service Coordinator should contact the RRDS for technical assistance. The RRDS will contact the provider and assist in obtaining the ISR.

Repeated late submissions of the ISR will result in the RRDS removing the provider from the list of available providers until the problem is resolved. Chronic late submissions of ISR may result in disenrollment of the provider.

Changing HCBS/TBI Waiver Providers

The HCBS/TBI waiver participant has the right to select a new provider at any time during the period covered by an approved Service Plan.

There are many reasons why a participant may choose to change providers, including but not limited to:

- A desire to maintain consistent services with an individual provider who changes employment from one provider agency to another.
- A change in the residence of the participant.
- A change in the needs or desired outcomes of the participant.
- Dissatisfaction with the timeliness, consistency, responsiveness or quality of current

services.

DOH has the responsibility to assure informed choice of providers for all participants. In the event of coercion by providers, the provider will be subject to appropriate remedial actions. Such actions may include suspension of the ability to provide services to new participants or disenrollment of the agency as an approved HCBS/TBI waiver provider.

Changing a Provider Based on a Request from the Participant

If the participant chooses to change their provider, the Service Coordinator must comply with the following procedure:

- The participant, his/her guardian, his/her advocate or current Service Coordinator informs the current provider of the participant's intention to change providers.
- The provider may request an opportunity to discuss this decision with the participant. If the meeting occurs, the waiver participant may invite anyone to attend and participate in the discussion.
- If the participant refuses to meet with the current provider, or if after the meeting the participant still chooses to change providers, a Change of Provider form will be sent by the Service Coordinator to the RRDS. His/her current Service Coordinator, guardian or advocate may assist the participant in completing the form.
- The Change of Provider form shall include: the participant's name, the service being changed, the names of the current and new service providers, and the requested effective date for the transition to the new provider.
- The Service Coordinator sends a copy of the Change of Provider form to the RRDS and the current and new providers.
- The RRDS reviews the request and sets a date for the change. The RRDS will send the Verification of Provider Change form to the participant, Service Coordinator and the current and new providers.
- The participant, Service Coordinator or any provider may contact the RRDS if this procedure is not followed.

Changing Providers As a Result of Staff Leaving

When a staff member of a provider agency will no longer be providing services to a participant, the following procedures must be followed:

1. The staff member notifies the Service Coordinator of the termination of services.
2. The staff member notifies the participant and directs them to discuss the impact of the termination with his/her Service Coordinator. If it is the Service Coordinator who is terminating services, the participant will be directed to the RRDS to select a new Service Coordinator.

3. The Service Coordinator meets with the participant to determine if a new provider is desired and amend the current Service Plan to reflect the change.

Establishing the Date of Termination

- Service Coordination must change on the first of the month.
- Other waiver services may be changed within ten business days from the RRDS receipt of the signed Change of Provider form. The RRDS may make the change of providers effective upon receipt of the Change of Provider form if it is determined that the health and welfare of the participant is at risk. This may be accomplished verbally or in writing.

During the transition period, the Service Coordinator will arrange for a meeting between the current and new providers and the participant to exchange information. The current provider is responsible for providing the new provider with copies of all evaluations, Individual Service Reports, and an update of what has been accomplished since the last Service Plan. This process must comply with all laws, such as the Health Insurance Portability and Accountability Act (HIPAA), regarding confidentiality and the release of medical and HCBS/TBI waiver services material.

Waiver Provider Contact List

1. The Service Coordinator compiles the list of all service providers for the participant. This list includes the services provided, names of the provider agencies, names of the persons providing the services and their phone numbers, names of their supervisor, and the supervisor's phone number. Also included is contact information for the RRDS.

2. Providers are responsible for contacting the Service Coordinator when this list must be updated.

3. The Service Coordinator provides a copy of the list of services and phone numbers to the participant and to all service providers.

4. The Service Coordinator retains a copy of the most updated contact list in the participant's file.

This process must be repeated each time a new waiver service is started, when there is a change in the person providing the service or provider agency, and at least every six months with the submission of a Revised Service Plan.

Section VI

Waiver Services

THE HCBS/TBI WAIVER SERVICES

Introduction

The HCBS/TBI waiver services are designed to address the unique needs of eligible individuals. All other services including informal supports, non-Medicaid services and those services provided through the Medicaid State Plan and other federally funded services must be explored and used, as appropriate, prior to utilizing waiver services. The provision of waiver services must be cost-effective and necessary to avoid institutionalization. When waiver services are appropriately combined with other services, individuals with traumatic brain injury can live in the community.

The purpose of each waiver service and the roles and responsibilities of the service provider are described in this section. The description of each waiver service includes:

(A) Definition of the Waiver Service

The definition indicates the purpose for the service and outlines the roles and responsibilities of the service provider.

(B) Provider Qualifications

This section identifies the variety of educational and employment experiences acceptable to become a qualified service provider. One year of qualifying employment is equivalent to 12 months of full time employment. Part time employment must be prorated, (e.g., two years of half time employment is equal to one year of employment). Internships and experience obtained in order to receive any degree required as a provider does **not** count toward qualifying experience.

(C) Reimbursement for Service

Only those services which are provided by a DOH approved provider and included in the Service Plan will be reimbursed. Billable units vary depending on the service and Medicaid may only be billed after the service has been delivered and/or completed.

Due to cognitive, physical or behavioral limitations related to a traumatic brain injury (e.g. short term memory, low frustration level, etc.), a participant may benefit from services in shorter intervals than the billable unit of service. In these situations, units of service may be accumulated in 15-minute intervals and billed when a full billable unit has been provided. The provider is responsible for maintaining sufficient documentation to verify the dates and times for services provided.

Example: A participant receives a service twice a week at 30 minutes each visit but the unit of service billable to Medicaid is one hour. The provider will bill for one hour of service after the second 30 minute session.

Service Coordination

Definition

The Service Coordinator assists the prospective participant to become a waiver participant and coordinates and monitors the provision of all services in the Service Plan. Services may include Medicaid State Plan services, non-Medicaid federal, state and locally funded services, as well as educational, vocational, social, and medical services. The goal is to increase the participant's independence, productivity and integration into the community while maintaining the health and welfare of the individual.

Roles and Responsibilities

The participant is the primary decision-maker in the development of goals, and selection of supports and individual service providers. The Service Coordinator is responsible for assuring that the Service Plan is implemented appropriately and supporting the participant to become an effective self-advocate and problem solver. Together they work to develop and implement the Service Plan, which reflects the participant's goals.

The Service Coordinator assists the participant in the development, implementation and monitoring of all services in the Service Plan. Additionally, the Service Coordinator must initiate and oversee the assessment and reassessment of the participant's level of care and on-going review of the Service Plan.

Questions that a Service Coordinator should explore with the participant include:

- What are the participant's goals?
- What can be done to help the participant fulfill his goals?
- How can the participant be assisted to become a member of the community?
- What can be done to assist the participant to be more independent?

The Service Coordinator must also be an effective advocate for the participant, ensure that the participant is receiving appropriate and adequate services from providers and maintain quality assurance.

Service Coordination has two basic components: Initial and Ongoing Service Coordination.

Initial Service Coordination encompasses those activities involved in developing the individual's Application Packet. After the individual selects a Service Coordinator, it is the Service Coordinator's responsibility to gain a full understanding of who this person is now, his/her life experiences, and his/her goals for the future. It is essential to interview those individuals who are of primary importance to the potential participant. Information from community services and medical facilities including information from a discharging facility should be obtained.

In assisting the individual to develop the Initial Service Plan, the Service Coordinator should look to sources of support – informal caregivers (family, friends, neighbors, etc.), non-Medicaid services, such as VESID, and Medicaid funded services (physician, personal

care, nursing, etc.). The waiver services are designed to complement other available supports and services available to Medicaid recipients.

Another important task of the Service Coordinator is to assist the participant in locating a place to live in the community. The HCBS/TBI waiver supports the individual's right to choose where to live and to have access to generic affordable and accessible housing. The Service Coordinator must complete a Housing Standards Checklist for waiver participants receiving a TBI Housing subsidy with the Initial Service Plan and annually in accordance with TBI Housing Guidelines.

There are no certified residences specifically/directly associated with the waiver; participants may live with up to three (3) other non-related individuals, unless they are in a living situation which is certified or licensed by the State (e.g. an Individual Residential Alternative or Adult Home). The Service Coordinator may assist the waiver participant and other supports to secure housing. In the RRDC regions of New York City, Hudson Valley and Long Island, assistance in locating housing is done by an agency under contract with DOH. Technical assistance to the Service Coordinator about housing issues is available through the RRDS.

Ongoing Service Coordination begins after the individual is approved to become a waiver participant. The Service Coordinator is responsible for the timely and effective implementation of the approved Service Plan. The Service Coordinator is responsible for assuring that there is adequate coordination, effective communication, and maximum cooperation between all sources of support and services for the participant.

The ultimate responsibility for assuring that the Service Plan is appropriately implemented rests with the Service Coordinator.

A Service Coordinator must be knowledgeable about all waiver services, Medicaid State Plan Services, and non-Medicaid services. Informal supports are often a crucial factor if the participant is to live a satisfying life and remain in the community. The Service Coordinator's ability to make use of these informal supports is essential, and offers the Service Coordinator and other providers the greatest opportunity for creativity.

The Service Coordinator will also be responsible for:

- Formally reviewing, updating and submitting Service Plans to the RRDS for review (refer to the Service Plan section of this Manual for specific information on Service Plan responsibilities);

- Organizing and facilitating Team Meetings;

3. Maintaining records for at least seven years after termination of waiver services;

4. Assuring that the PRI/SCREEN is completed:

    a. at least every twelve months; or
    b. when the participant experiences a significant improvement in his/her ability to function independently in the community.

5. Maintaining records of waiver transportation as described in the Manual section on Transportation Services;

6. Assuring that all waiver service providers and the participant receive a current copy of the most recently approved Service Plan;

7. Maintaining knowledge of all approved waiver service providers in their region; and

8. Conducting in-home visits with the participant no less than once a quarter.

Although the Service Coordinator may be an employee of a provider agency, the Service Coordinator must always act as a neutral advocate in assisting the participant with the selection of providers.

Ratio of Waiver Participants to Service Coordinator

- Full time Service Coordinators for HCBS/TBI waiver participants may not exceed a caseload of seventeen (17) waiver participants.

- Service Coordinators providing services to HCBS/TBI waiver participants on less than a full time basis must limit their caseload proportionately. For example, a Service Coordinator working 50 percent may not exceed a caseload of eight (8) HCBS/TBI waiver participants.

Provider Qualifications

Not-for-profit or proprietary health and human services agencies may provide Service Coordination. The agency must be approved by DOH as a waiver provider.

Service Coordinators must be a:

(A) (1) Master of Social Work;
(2) Master in Psychology;
(3) Registered Physical Therapist;
(4) Professional Registered Nurse;
(5) Certified Special Education Teacher;
(6) Certified Rehabilitation Counselor;
(7) Licensed Speech-Language Pathologist; or
(8) Registered Occupational Therapist.

The provider shall have, at a minimum, **one (1) year** of experience providing Service Coordination and information, linkages and referrals regarding community-based services for individuals with disabilities; OR

(B) Be an individual with a Bachelor's degree and two (2) years experience providing Service Coordination for individuals with

disabilities and knowledge about community resources; OR

(C) Be an individual with a High School Diploma with three (3) years experience providing Service Coordination for individuals with disabilities and knowledge about community resources; OR

(D) Be an individual who has successfully served as a Regional Resource Development Specialist for one (1) year.

Individuals identified in section (A) may supervise the following individuals to perform Service Coordination Services:

- Individuals with educational experience listed in (A) but who do not meet the experience qualification;
- Individuals with a Bachelor's degree in health or human services with one (1) year of experience providing Service Coordination for individuals with disabilities and knowledge about community resources; and
- Individuals with a High School Diploma and two (2) years of experience providing Service Coordination to individuals with disabilities and knowledge about community resources.

The supervisor is expected to:

1. Meet any potential participants prior to the completion of the Initial Service Plan developed by a Service Coordinator under their supervision;
2. Have supervisory meetings with staff on at least a bi-weekly basis; and
3. Review and sign-off on all Service Plans.

A supervisor may maintain an active caseload of waiver participants in accordance with ratio guidelines.

Self-Employment

Professionals listed in (A) and (D) of this section who are self-employed may be Service Coordinators. In addition to the educational requirement, individuals eligible under part (A) must have three (3) years experience providing Service Coordination involving multiple community resources to individuals with traumatic brain injury and have an understanding of the philosophy and content of this waiver. For individuals eligible under part (D), there are no additional education or experience requirements.

Team Meetings

The Service Coordinator must be a strong and effective team leader. After the participant has selected all service providers, the Service Coordinator organizes the team to provide individualized services for the participant. The Service Coordinator needs to coordinate communication among all team members, including the participant. This becomes especially important when cognitive deficits affect the participant's memory. Maintaining good communication contributes towards effective coordination of services to support the

participant in the community.

Team Meetings must be coordinated and facilitated by the Service Coordinator and must occur, at a minimum, every six months when a Revised Service Plan is developed. The participant, his/her legal guardian if applicable, and all waiver service providers for the individual must attend each Team Meeting. Failure to attend may jeopardize the ability of the waiver provider to continue to provide waiver services. Providers of essential non-waiver services and anyone identified in the Plan for Protective Oversight should also be invited to Team Meetings. Other potential members include advocates, family members, local department of social services staff, co-workers, etc. If the waiver participant is receiving the same service from different waiver providers, both providers should attend the Team Meeting. If the participant is receiving a service from several providers in the same agency, only one representative needs to attend.

The Service Coordinator is responsible for assuring effective communication between the participant and all service providers. To assure services are provided in the most integrated and efficient manner, it is necessary for providers to attend regularly scheduled Team Meetings to discuss progress toward the participant's goals, identify any impediments to achieving projected milestones and address any issues affecting the participant. Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant's health and welfare.

Team Meetings are scheduled based on the service needs of the participant. A new waiver participant may benefit from monthly meetings while for an individual whose situation is stable, Team Meetings must be held every six months when the Revised Service Plan is developed. The RRDS may consult with the Service Coordinator to determine if Team Meetings are being used appropriately.

On limited occasions, service providers may indicate the need to meet without the participant (e.g. the participant's behavior or other factors jeopardize the participant's ability to remain in the community). The Service Coordinator is responsible for informing the RRDS of the team's interest in holding a meeting without the participant. Following the meeting, the Service Coordinator and other members of the team must meet with the participant to explain the results of the meeting. This exception does not apply when the team is meeting to develop a Revised Service Plan.

Team Meetings must be documented in the Service Plan and written in the projected activities of the Service Coordinator and waiver providers. Participation in Team Meetings must be documented in the notes of each service provider.

Team Meetings are organized and facilitated by the Service Coordinator as part of his/her responsibility to oversee services. Reimbursement for this activity is included in the monthly rate for Service Coordination. All other waiver service providers participating in a Team Meeting will be reimbursed at the usual rate for their service (e.g. CIC will be able to bill as a face-to-face session with the participant).

Reimbursement for Service Coordination

Service Coordination must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

There are two types of reimbursement for Service Coordination:

Initial Service Coordination is reimbursed on a one-time only basis for each participant after the individual is an approved participant in the waiver. Reimbursement is for the work, time and travel expended in developing the Application Packet, including the Initial Service Plan.

Ongoing Service Coordination is reimbursed on a monthly basis. As with all waiver services, Service Coordination must be included in the Service Plan. The Service Coordinator must have, at a minimum, one face-to-face contact with the participant per month. At least quarterly, one of these visits must occur in the participant's home.

Independent Living Skills Training and Development Services (ILST)

Definition

It is the responsibility of the ILST provider to conduct a comprehensive functional assessment of the waiver participant, identifying the participant's strengths and weaknesses in performing Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) related to his/her established goals. The assessment is the basis for developing an ILST plan that describes the milestones and interim steps necessary to attain these goals. The assessment must also include a determination of the participant's manner of learning new skills and responses to various interventions. This comprehensive and functional assessment must be conducted at least annually from the date of the last assessment.

ILST services may include assessment, training, and supervision of, or assistance to, an individual with issues related to self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, problem solving skills, money management, pre-vocational skills and skills to maintain a household.

ILST services are individually designed to improve the ability of the participant to live as independently as possible in the community. ILST may be provided in the participant's home or in the community. This service is provided on an individual basis.

ILST must be provided in the environment and situation that will result in the most positive outcome for the participant. It is expected that this service will be provided in the real world, such as in the participant's kitchen as opposed to an agency's kitchen. This requirement addresses the difficulty many participants experience with transferring or generalizing knowledge and skills from one situation to another. However, it is recognized that there is need for some practice of skills before using them in the environment.

ILST services may also assist a participant with "real world" paid or unpaid (volunteer)

employment. The use of ILST for vocational purposes may occur only when the services of Vocational and Educational Services for Individuals with Disabilities (VESID) have been fully explored and it is determined that the participant is not eligible for VESID services or VESID does not provide the needed service.

ILST providers are responsible for training the participant's informal supports and waiver and non-waiver service providers to provide the type and level of supports that allow the participant to become as independent as possible in ADLs and IADLs. ILST is a time limited service used to assess a participant's needs, develop a plan and train others to assist the participant. ILST is not intended to be a long-term support. The reasons to provide or continue ILST must be documented in the Service Plan.

Provider Qualifications

ILST may be provided by any not-for-profit or proprietary health and human services agency. Self employed individuals meeting the qualifications may also provide this service.

An ILST must be a:

(A) (1) Registered Occupational Therapist;
(2) Registered Physical Therapist;
(3) Speech-Language Pathologist;
(4) Registered Professional Nurse;
(5) Certified Special Education Teacher;
(6) Certified Rehabilitation Counselor;
(7) Master of Social Work; or
(8) Master of Psychology.

These individuals must have, at a minimum, one (1) year of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities to be more functionally independent; OR

(B) An individual with a Bachelor's degree and two (2) years of similar experience; OR

(C) An individual with a High School Diploma and three (3) years of similar experience.

Individuals identified in section (A) may supervise the following individuals to perform ILST services:

- Individuals with the educational experience listed in section (A) but who do not meet the experience qualifications;
- Individual with a Bachelor's degree with one (1) year of experience;
- Individuals with a High School Diploma and two (2) years of experience; and
- Individuals who have successfully completed two (2) years of providing Home and Community Support Services or Residential Habilitation under the

Office of Mentally Retarded and Developmental Disabilities HCBS waiver.

The supervisor is responsible for:

- Completing an initial assessment of the participant's functional abilities and developing a detailed plan of intervention;
- Training a service provider to implement the plan so that maximum benefit to the participant may occur;
- Re-evaluating the participant as needed, but not less than at the completion of the Individual Service Report (included in all Revised Service Plans) and whenever Addendums to the Service Plan are written, which include changes in the amount and/or frequency of this service; and
- Providing ongoing supervision and training to staff. Such training must occur no less than once a month when the caseload is reviewed. Supervision must be more frequent when there is a new participant, new provider or when there is evidence that the expected progress is not occurring.

The ILST provider agency must make every possible effort to match the skills and experience of the individual provider to the specific goals of the participant.

Self-Employment

Individuals listed in (A) of this section who are self-employed may provide ILST services. In addition to the educational requirement, such individuals must have three (3) years of experience providing functionally based assessments and independent living skills training to individuals with traumatic brain injury, and demonstrate an understanding of the philosophy and content of the HCBS/TBI waiver.

Reimbursement

ILST must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

ILST is provided on an individual, hourly basis. Only in rare situations where the participant benefits specifically from a group setting will this service be approved on other than an individual basis. In such situations, the provider may bill for the percentage of the time spent with a participant (e.g. when the ILST is provided to two participants for two hours, the provider will bill one hour for each participant). Training provided to informal supports or waiver or non-waiver service providers must be included in the Service Plan in order to be reimbursed.

ILST providers participating in Team Meetings will be reimbursed at the hourly rate for their time at the Team Meeting.

Structured Day Program Services

Definition

Structured Day Program services are individually designed services, provided in an

outpatient congregate setting or the community, to improve or maintain the participant's skills and ability to live as independently as possible in the community. Services may include assessment, training and supervision of, or assistance to, an individual with issues related to self-care, medication management, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills, and skills to maintain a household.

Structured Day Program services may be used to reinforce aspects of other HCBS/TBI waiver and Medicaid State Plan services. This is permitted due to the difficulty many individuals with traumatic brain injury have transferring or generalizing skills learned in one setting to other settings and the need for consistent reinforcement of skills. This service is intended to provide an opportunity for the participant to continue to strengthen skills that are necessary for greater independence, improved productivity and/or increased community inclusion.

The Structured Day Program service may be provided within a variety of settings and with very different goals. Participants may choose to participate in a Structured Day Program that emphasizes basic work skills, such as punctuality, problem solving and effectively communicating with co-workers and supervisors. Other Structured Day Programs may focus on specific job skills, such as computer operation, cooking, etc. Other participants, for whom employment is not an immediate goal, may be more interested in community inclusion and improving their socialization skills.

The Structured Day Program is responsible for meeting the functional needs of those served. The Program must provide adequate protection for the personal safety of the program participants, including periodic fire drills. The Structured Day Program must be located in a building that meets all provisions of the New York State Uniform Fire Prevention and Building Codes. In addition, access to the Program must meet and adhere to the requirements of the Americans with Disabilities Act. If the RRDS or DOH identify questionable situations, appropriate referrals will be made for necessary corrective action.

Whatever type of Structured Day Program(s) the participant chooses, it is essential that there be coordination between providers, assuring consensus in the type of supports and structures that are used in all settings and avoiding duplication of services. This is particularly important when the participant is receiving waiver services such as Independent Living Skills Training, Intensive Behavioral Program, and Home and Community Support Services.

An identified best practice is to have day programs specifically designed to meet the needs of individuals with TBI. Often individuals with traumatic brain injuries recognize that there are significant differences between themselves and other consumers of day programs, (i.e. individuals with mental retardation, developmental disabilities or mental health difficulties). The structure, organization, activities and staff training needs are also different.

If a Structured Day Program includes the opportunity for participants to earn money, the provider must comply with all existing federal labor laws.

Provider Qualifications for the Director of Structured Day Programs

Structured Day Programs may be provided by any not-for-profit or proprietary health and human services agency. All Structured Day Programs must be identified in the Service Plan and provided by agencies approved as a provider of this waiver service by DOH.

These programs must be directed by an individual who is a:

(A) (1) Registered Occupational Therapist;
(2) Registered Physical Therapist;
(3) Licensed Speech-Language Pathologist;
(4) Registered Professional Nurse;
(5) Certified Special Education Teacher;
(6) Certified Rehabilitation Counselor;
(7) Master of Social Work; or
(8) Master of Psychology.

Structured Day Program Directors must have, at a minimum, one year of experience providing functional assessments, Intensive Behavioral Services or Structured Day Program services to individuals with traumatic brain injury; OR

(B) Individual with a Bachelor's degree and two years of similar experience.

Reimbursement

Structured Day Program services must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

Structured Day Program services are reimbursed on an hourly basis, not to exceed eight hours per day. Participation in Team Meetings organized by the Service Coordinator is reimbursed at the hourly rate.

The provision of Structured Day Program services must not occur in a sheltered workshop environment. If a participant decides to make use of the services of a sheltered workshop, the reimbursement for that service must be provided through VESID.

Substance Abuse Program Services

Definition

Substance Abuse Program services provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the participant, which, if not effectively dealt with, will interfere with the individual's ability to remain in the community.

Substance Abuse Program services are provided in an outpatient group setting and may include an assessment of the individual's substance abuse history; learning/behavioral assessment; development of a structured treatment plan which reflects an understanding of the participant's substance abuse history and cognitive abilities; implementation of the

plan; on-going education and training of the participant, family members, informal supports and all other service providers; individualized relapse strategies; periodic reassessment of the plan; and ongoing support. The treatment plan may include both group and individual interventions and must reflect the use of curriculum and materials adopted from a traditional substance abuse program to meet the needs of individuals with traumatic brain injury.

The Program must develop a detailed plan describing how it will work with existing community support programs, such as Alcoholics Anonymous and secular organizations for sobriety, that provide ongoing support to individuals with substance abuse problems. Substance Abuse Program Services are also required to provide technical assistance to community-based self-help/support groups to improve the ability of the community support programs to provide ongoing supports to individuals with traumatic brain injury.

All Substance Abuse Program services must be documented in the Service Plan and must be provided by individuals or agencies approved as providers of the waiver services by DOH.

Individuals who may have been substance abusers in the past are not precluded from being a Substance Abuse Program provider. Substance Abuse Programs must have a written policy regarding consequences of any individual providing services who develops a substance abuse problem. No one abusing substances is allowed to work with HCBS/TBI waiver participants.

Individuals with a TBI have experienced very little success with using traditional substance abuse programs (often based on the 12-Step program) as the requirements associated with that program depend on cognitive abilities that may be difficult for individuals with a brain injury. It is essential that staff members in leadership positions are knowledgeable about both substance abuse treatment and working with individuals with cognitive deficits.

The Substance Abuse Program is responsible for meeting the functional needs of the participants served. The Program must provide adequate protection for the Program participants' safety and fire safety, including periodic fire drills, and must be located in a building that meets all provisions of the New York State Uniform Fire Prevention and Building Codes. In addition, access to the Program must meet and adhere to the requirements of Americans with Disabilities Act. If the RRDS or DOH identify questionable situations, appropriate referrals will be made for necessary corrective action.

Provider Qualifications for Director of the Substance Abuse Program

Substance Abuse Program services may be provided by any not-for-profit or proprietary health and human services agency AND must be certified/licensed by the Office of Alcoholism and Substance Abuse Services (OASAS).

All Substance Abuse Program services must be documented in the Service Plan and be provided by agencies approved as providers by DOH AND certified/licensed by OASAS.

The Program Director must be a health care professional with an advanced human services degree such as a:

1. Master of Social Work;
2. Certified Rehabilitation Counselor;
3. Registered Occupational Therapist;
4. Registered Physical Therapist;
5. Licensed Speech-Language Pathologist;
6. Professional Registered Nurse;
7. Master of Psychology; or
8. Certified Special Education Teacher.

These individuals must have at least one year experience providing services to individuals with traumatic brain injury or providing services to individuals who abuse substances (e.g. Certified Alcoholism and Substance Abuse Counselor). If the Director has experience in only one of these areas, then there must be staff members in positions of significant policy making, procedure development and/or provision of service who have experience in the other.

At least one staff member must be a Certified Alcoholism and Substance Abuse Counselor.

Reimbursement

Substance Abuse Program services must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

This service is reimbursed on an hourly basis, not to exceed five hours per day. Participation in Team Meetings is reimbursed at the hourly rate.

Intensive Behavioral Program (IBP)

Definition

IBP services are provided to participants who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment. The primary goal of IBP services is to decrease the intensity or frequency of targeted behaviors, and to teach more socially appropriate behaviors.

IBP services include but are not limited to:

- A comprehensive assessment of the individual's behavior in the context of his/her abilities/disabilities and the environment which precipitates the behaviors.
- A detailed behavioral treatment plan including a clear description of successive levels of intervention starting with the simplest and least intrusive.
- Arrangements for training informal supports and waiver and non-waiver service providers to effectively use the basic principles of the behavioral plan.
- Regular reassessments of the effectiveness of the plan and modifying the plan as needed.
- An emergency intervention plan when there is the possibility of the participant

becoming a threat to himself, herself or others.

Provider Qualifications for Director of the Intensive Behavioral Program

IBP services may be provided by any not-for-profit or proprietary health and human services agency. The two key positions in IBP service are the Program Director and the Behavioral Specialist.

The Program Director is responsible for developing the IBP plan for each participant. The Director may work as a Behavioral Specialist or provide ongoing supervision to a Behavioral Specialist who will implement the plan.

If a provider has more than one individual who meets the qualifications for the Program Director, all qualified individuals may develop individual IBP plans.

The Program Director must be a:

(A) Licensed psychiatrist with one year experience providing behavioral services; OR

(B) Licensed psychologist with one year experience in providing behavioral services or traumatic brain injury services; OR

(C)
1. Master of Social Work;
2. Master in Psychology;
3. Registered Occupational Therapist;
4. Registered Physical Therapist;
5. Licensed Speech-Language Pathologist;
6. Registered Professional Nurse;
7. Certified Rehabilitation Counselor; or
8. Certified Special Education Teacher.

Each of the individuals in (C) must have, at a minimum, two years of experience providing neurobehavioral services; OR

(D) Individual who has been a Behavioral Specialist for two years and has successfully completed the apprenticeship program offered by the Statewide Neurobehavioral Resource Project.

Provider Qualifications for Behavioral Specialists

The Behavioral Specialist is responsible for implementation of the individual intensive behavioral plans under the direction of the Program Director and must be a:

(A) Person with a Bachelor's Degree;
(B) Registered Professional Nurse;
(C) Certified Occupational Therapy Assistant; or
(D) Physical Therapy Assistant.

The Behavioral Specialist must have at least one year of experience working with people with traumatic brain injury, other disabilities or behavioral difficulties. The Behavioral Specialist must successfully complete forty hours training in traumatic brain injury, behavioral analysis, and crisis intervention techniques which is provided by the Intensive Behavioral Program. The Program Director will provide ongoing training and supervision to the Behavioral Specialist.

Supervision must occur no less than biweekly when the caseload is reviewed and must be more frequent when there is a new participant, new provider or when significant behavioral issues arise.

Self-employment

Self-employed individuals must meet the qualifications of the Program Director of the Intensive Behavioral Program.

Reimbursement

Intensive Behavioral Program services must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

This service is reimbursed on an hourly basis. Participation in Team Meetings is reimbursed according to the hourly rate for this service.

Community Integration Counseling Service (CIC)

Definition

CIC is an individualized service designed to assist the waiver participant to more effectively manage the emotional difficulties associated with adjusting to and living in the community. It is a counseling service provided to a participant coping with altered abilities and skills, the need to revise long term expectations, and changed roles in relation to significant others. This service is generally provided in the provider's office or the participant's home. It is available to participants and/or anyone involved in an ongoing significant relationship with the participant when the issues to be discussed relate directly to the participant.

While CIC is primarily provided in a one-to-one counseling session, there are times when it is appropriate to provide this service to the participant in a family counseling or group counseling setting.

Regarding client confidentiality, the sharing of information obtained during a CIC session can only be disclosed in accordance with accepted professional standards regarding client confidentiality.

CIC must **not** be used to assist the participant to become physically integrated into his/her environment. This function is the responsibility of other service providers, such as Service Coordinators, ILST and HCSS.

Provider Qualifications

CIC may be provided by any not-for-profit or proprietary health and human services agency. Qualified self employed individuals may also provide this service.

A CIC must be a:

(A)
1. Licensed Psychiatrist;
2. Licensed Psychologist;
3. Master of Social Work;
4. Master of Psychology;
5. Certified Rehabilitation Counselor; or
6. Master of Counseling Psychology.

Each of these individuals must have a minimum of two years of experience providing adjustment related counseling to individuals with traumatic brain injuries and their families. A significant portion of the provider's time which represents this experience must have been spent providing counseling to individuals with traumatic brain injuries and their families in order to be considered qualifying experience.

Individuals listed in (A) may supervise the following individuals to perform CIC services:

(B)
1. Licensed Psychologist;
2. Certified Rehabilitation Counselor;
3. Licensed Psychiatrist;
4. Master of Social Work;
5. Master of Psychology; or
6. Master of Counseling Psychology.

Individuals in section (B) must have, at a minimum, one year of experience providing adjustment related counseling to individuals with physical, developmental or psychiatric disabilities.

Supervisors are responsible for providing ongoing supervision and training to staff. Supervision must occur no less than once a month when reviewing the caseload and must be more frequent when there is a new participant, a new provider or there has been a significant change in the participant's emotional, psychiatric or life situation.

Self-Employment

Individuals meeting the requirements described in section (A) above may be self-employed and provide this service.

Reimbursement

CIC services must be provided by a DOH approved provider and must be included in the Service Plan to be reimbursed.

CIC is reimbursed in one hour units. Participation in Team Meetings is reimbursed at the hourly rate for this service.

If CIC is provided in a group setting, the hourly rate is divided evenly among the participants. For instance, if the participant is one of four people in the group, only one quarter of an hour is billable to that participant. Providers must accumulate billable units until a whole hour is reached before billing for the service.

Home and Community Support Services (HCSS)

Definition

HCSS are individually designed support services essential for the participant's health and welfare. These services include cuing, prompting and supervision with activities of daily living (ADLs) and Independent Activities of Daily Living (IADLs), such as bathing, personal hygiene tasks, dressing, meal preparation, eating, light and heavy household tasks, laundry, transportation and shopping, as well as supporting integration into the community.

HCSS is not intended as a "hands-on" service for ADLs and/or physical assistance. These needs are best met by services provided under State Plan Medicaid, such as Personal Care Services (PCS), including Consumer Directed Personal Assistance, or Home Health Aide (HHA) Services. HCSS cannot assist with the administration of medication, dress open wounds, assist with tube feedings, or perform any other activities that are within the scope of practice of a nurse, PCS or HHA under any circumstance.

HCSS are provided under the direction and supervision of the HCSS agency. Usually, an ILST will complete an assessment and develop a detailed plan for cuing, prompting or supervising the participant in ADLs and IADLs. The ILST will train the HCSS staff to implement the Detailed Plan and provide the intervention. The Behavioral Specialist may also train the HCSS staff in behavioral interventions based on a Detailed Plan.

HCSS differ from PCS provided under the Medicaid State Plan in that individuals receiving PCS must have a medical need and do not receive safety monitoring oversight and/or supervision as a discrete task.

It is important to consider the interests and needs of the waiver participant when assigning HCSS support. The ability of the HCSS to support the strengths, interests and needs of the participant will promote a better working relationship and help to meet the established goals for the service. It is the right of the participant to request a change in HCSS worker. However, attempting to find the best match between HCSS worker and participant from the start decreases the occurrence of staff turnover and Serious Reportable Incidents while increasing participant satisfaction and success in the community.

The HCSS has periods of extended time to observe the waiver participant and the impact of interventions established by other waiver services such as ILST and IBP. Input from the HCSS should be considered during Team Meetings to assess the affectiveness of these interventions.

The agency providing HCSS Services must have an HCSS supervisor to oversee the

provision of service and provide direction to the HCSS. The provider is also responsible for assuring sufficient back-up for the HCSS.

Provider Qualifications

HCSS may be provided by a not-for-profit or proprietary health and human services agency.

The HCSS must:

- Be at least 18 years old;
- Be able to follow written and verbal instructions; and
- Have the ability and skills necessary to meet the participant's needs that will be addressed through this service.

Reimbursement

HCSS services must be provided by a DOH approved provider and included in the Service Plan to be reimbursed.

HCSS services are reimbursed on an hourly basis. When HCSS staff provide services to more than one person at a time, the ratio of provider to participants must be stated in the Service Plan and the billing must be prorated. Example: HCSS is providing services to two individuals living together for six hours. The Service Plan for each individual reflects a 1:2 ratio and billing reflects three hours per person.

While it is beneficial for HCSS staff to participate in the Team Meetings, only the supervisor or one HCSS staff from an agency may be reimbursed for attending.

Respite Care Services

Definition

Respite Care Services may be included in the Service Plan to provide relief to informal, non-paid supports who provide primary care and support to a participant. These services are usually provided in the participant's home.

Services may be provided in another home in the community if this is acceptable to the participant and the people living there. If a participant is interested in seeking a brief respite in a nursing facility, this can be accomplished through a scheduled short term admission.

Provider Qualifications

Providers of Respite Care Services must meet the same standards and qualifications as the HCSS. If the participant needs services beyond HCSS, then the other services must be included in the Plan with Respite Care Services.

Reimbursement

Respite Care Services must be provided by a DOH approved provider and included in the Services Plan to be reimbursed.

Respite Care Service is provided in blocks of 24 consecutive hours. Since Respite Care Service is provided on an intermittent basis, the Service Coordinator must determine when participation in Team Meetings is appropriate.

Environmental Modifications Service (E-mods)

Definition

Environmental Modifications are internal and external physical adaptations to the home, which are necessary to ensure the health, welfare and safety of the individual. E-mods also include modifications to a vehicle. These modifications enable the participant to function with greater independence and prevent institutionalization.

E-mods must be provided where the participant lives. E-mods may be obtained at the time the individual becomes enrolled as a participant, up to thirty days prior to a Notice of Decision, or during the development of any Service Plan. Modifications must not be completed more than thirty days prior to the issuance of the Notice of Decision. All modifications must meet State and local building codes.

If necessary, an E-mod may alter the basic configuration of the participant's home. All environmental and vehicle modifications must be included in the Service Plan and provided by agencies approved by DOH.

E-mods must be less than $15,000 per modification and limited to no more than one modification within a 12 month period. A contract for E-mods in the amount of $15,000 or more must be approved by DOH. Approval of modifications is contingent upon available funding.

E-mods do not include improvements to the home (carpeting, roof repair, central air conditioning), which are not medically necessary or do not promote the participant's independence in the home or community.

Allowable Environmental Modifications

E-mods in the home include installation of:

- Ramps

- Lifts: hydraulic, manual or electric, for porch, bathroom or stairs (Lifts may also be rented if it is determined that this is more cost-effective.)
- Widened doorways and hallways
- Hand rails and grab bars
- Automatic or manual door openers and doorbells

Bathroom and kitchen modifications, additions or adjustments to allow accessibility or improved functioning, include:

- Roll-in showers
- Sinks and tubs
- Water faucet controls
- Plumbing adaptations to allow for cutouts, toilet/sink adaptations
- Turnaround space changes/adaptations
- Worktables/work surface adaptations
- Cabinet and shelving adaptations

Other home adaptations include:

- Medically necessary heating/cooling adaptations required as part of a medical treatment plan. (Any such adaptations utilized solely to improve a person's living environment are not reimbursable under the waiver.)
- Electrical wiring to accommodate other adaptations or equipment installation.
- Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that have been determined medically necessary.
- Other appropriate environmental modifications, adaptations or repairs necessary to make the living arrangements accessible or accommodating for the participant's independence and daily functioning and provide for emergency fire evacuation.

Provider Qualifications

Any not-for-profit or proprietary health and human services agency may provide E-mods. Agencies approved to provide E-mods by the Office of Mental Retardation and Developmental Disabilities (OMRDD). An organization that has both the personnel and expertise to complete the E-mod and is an approved Medicaid provider may also be approved by DOH to provide the services for HCBS/TBI waiver.

The E-mod provider must ensure that individuals working on the E-mods are appropriately qualified and/or licensed to comply with any State and local rules. All materials and products used must also meet any State or local construction requirements.

Safety issues addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act as well as all local building codes must be strictly adhered to.

Approval Process for E-mods for a home

STEP 1 The participant, Service Coordinator, and anyone selected by the participant determine if any E-mods are required during the development of any Service

Plan.

STEP 2 A comprehensive assessment must be completed to determine the specifications of the E-mod.

STEP 3 The participant, the Service Coordinator and anyone selected by the participant must explore all other available resources to pay for E-mods (i.e. informal supports, community resources and State/federal agencies).

STEP 4 When all other resources have been utilized, the Service Coordinator begins the bid procurement and selection process.

There are two options for obtaining bids:

1. The Service Coordinator and participant select a waiver approved E-mod provider to be responsible for planning, oversight and supervision of the project. The provider is then responsible for obtaining three bids from skilled professionals and selecting the contractor; OR

2. The Service Coordinator and participant obtain three bids from providers who are responsible for planning, oversight and supervision of the project AND have the personnel and expertise to complete the E-mod.

    - For E-mods of less than $1,000, only one bid is necessary.
    - For E-mods of $1,000 or more, three bids are necessary.

    Any combination of these two options can be used to obtain three bids. The lower bid must be selected, unless there is an indication that the contractor did not understand the full scope of the work or is unable to deliver the needed service. Every reasonable effort must be made to acquire the required three bids.

    When the Service Coordinator determines that the continued delay due to lack of the required number of bids is jeopardizing the participant's health and welfare or is preventing an individual from leaving an institution, the Service Coordinator must contact the RRDS. The RRDS will consult with DOH and will notify the Service Coordinator if they can proceed without the required three bids.

STEP 5 The Service Coordinator submits the E-mod proposal using the E-mod Project Description and Cost Projection form (Appendix C-2) to the RRDS for review and approval along with the Service Plan. Information that must be submitted includes but is not limited to:

1. Justification for the E-mod.
2. All comprehensive assessments completed to determine the specifications of the E-mod.
3. Information regarding the residence where the E-mod is proposed, including the name of the home owner or landlord. The owner's

approval for the renovations, including any lease or rental contract, must be included (DOH is not responsible for the cost of restoring a site to its original configuration or condition).

4. If the participant or family is having other renovations or repairs done to the house along with the E-mods, the scope of work should clearly delineate the waiver covered E-mods from modifications being funded by the family.

STEP 6 The RRDS reviews the E-mod proposal and may request more information. Approval is contingent upon available funding. The RRDS notifies the Service Coordinator of the approval.

STEP 7 The Service Coordinator notifies the E-mod provider of the approval and obtains a signed contract from the provider. The E-mod provider is responsible for coordination of the E-mod, including obtaining necessary permits, supervising the construction, beginning and ending dates, and satisfactory completion of the project.

Signed contracts must be forwarded to the RRDS and must be less than $15,000 per 12 month period. Any changes in cost must be prior approved by the RRDS through an Addendum to the Service Plan. A contract for E-mods in the amount of $15,000 or more must be approved by DOH.

STEP 8 Upon completion of the E-mod, a summary of the work, with actual costs, is submitted to the RRDS on the Environmental Modifications Final Cost form (Appendix C-2).

STEP 9 The RRDS reviews the Final Cost form, approves the final cost of the E-mod and notifies the Service Coordinator.

STEP 10 The Service Coordinator notifies the E-mod provider to seek reimbursement.

Repairs

Repairs for home modifications which are cost effective may be allowed. Modifications that have worn out through normal use (faucet controls, ramps, handrails, etc.) may be replaced using the same E-mod approval process as for new E-mods. Repair and/or replacement may be contingent upon developing and implementing a plan to minimize repeated damage.

Reimbursement

E-mods must be provided by a DOH approved provider and included in the Service Plan to be reimbursed. E-mods initiated up to thirty days prior to the initial Notice of Decision are reimbursed after the Notice is issued.

This service is reimbursed according to the final cost of the project approved by the RRDS and must be less than $15,000 per 12 month period. A contract for E-mods in the amount of $15,000 or more must be approved by DOH.

E-mods for Vehicles

Definition

Vehicle modifications provide the participant with the means to access services and supports in the community, increase independence and promote productivity. These modifications may include adaptive equipment and/or vehicle modifications.

Equipment that is available from the dealer by factory installation as standard or optional features of the car is not covered as a waiver service. These items, as well as ongoing maintenance and repair of the vehicle, are the responsibility of the participant.

The vehicle must be owned by the participant, a family member or an individual who provides primary long term support to the participant. Modifications will only be made to a vehicle if it is the primary source of transportation for the participant and it is available to the participant without restrictions.

All vehicles that are modified under the waiver must be insured and meet New York State inspector standards before and after the modifications are completed.

Vehicle modifications must be less than $15,000 per 12 month period. Vehicle modifications in the amount of $15,000 or more must be approved by DOH.

Allowable E-mods for Vehicles

Adaptive equipment is designed to enable a participant to operate a vehicle or be transported but are not usually available through the vehicle's manufacturer.

Adaptive equipment includes:

- Hand controls
- Deep dish steering wheels
- Spinner knobs
- Wheelchair lock downs
- Parking brake extensions
- Foot controls
- Wheelchair lifts, including maintenance contracts
- Left foot gas pedals

Vehicle modifications include adaptations and/or changes to the structure and internal design of existing vehicle equipment.

Vehicle modifications include:

- Replacement of a roof with a fiberglass top
- Floor cut-outs
- Extension of steering column
- Raised door

- Repositioning of seats
- Wheelchair floor
- Dashboard adaptations

Adaptive equipment and vehicle modifications may only be provided if the following conditions are met:

a. The participant is not eligible for these services through any other resource (e.g. VESID, Veterans Administration, Workers Compensation, insurances, etc.);

b. There is an acceptable written recommendation and justification by a VESID approved evaluator that the services are essential for the participant to drive or be transported in a motor vehicle; and

c. The participant and the owner of the vehicle must sign the statement, indicating that the vehicle is available to the participant without restrictions.

Limitations on adaptive equipment and vehicle modifications:

a. The Service Coordinator will instruct the VESID approved evaluator to recommend the most cost effective and least complicated adaptive equipment and vehicle modifications(s) which will meet the participant's functional capabilities and safety needs while also meeting appropriate requirements/standards.

b. A car may be considered for modification if the participant can independently transfer him/herself and a wheelchair into and out of the car, has the functional ability to drive the car, and does not have medical contraindications, which preclude the ability to transfer from and/or drive the car.

c. A van can only be considered for modification if a car cannot be modified to meet the participant's needs.

d. Modifications to a vehicle that the participant will not be driving are limited to modifications that are essential to insure safe transportation and access into and out of the vehicle.

e. Modifications may not exceed the Blue Book on current market value of the vehicle.

Used Vehicles

The HCBS/TBI waiver may cover the modification of used vehicles or the cost of modifications in a used vehicle only if the vehicle meets the following additional criteria:

a. The vehicle must pass New York State inspection be registered and insured;

b. The vehicle must be structurally sound and not in need of mechanical repairs;

c. The vehicle must not have any rust or deficiencies in the areas to be modified or in the areas already modified; and

d. The vehicle must be less than five years old or register less than 50,000 miles.

Used Adaptive Equipment

Used adaptive equipment and modification devices are sometimes available for purchase. To ensure the greatest safety and performance, DOH will only approve used equipment purchased from businesses dealing in the sale of vehicles or adaptive equipment. The equipment must be able to safely meet the participant's needs, as determined by an evaluation completed by a VESID approved evaluator, and be in good working condition as determined by the vehicle modifier.

Assessing the Value of Used Adaptive Equipment or Vehicle Modifications

a. Determine the value of the used vehicle (as though no modifications had been made) from the Blue Book. Subtract this figure from the asking price of the previously modified vehicle. The difference will be the asking price of the modification or adaptive equipment.

b. To determine the current value of the used modification or adaptive equipment, ascertain the original cost of the modification from the dealer. Adaptive equipment depreciates 10% each year. Calculate the current value of the modification based on the 10% depreciation. This figure is the current value of the modification or adaptive equipment. This is the amount that Medicaid may cover provided it does not exceed the vehicle modification limits specified in this Manual.

Repairs

Waiver services do not include general repairs or maintenance of a vehicle. All warranties and guarantees must be fully utilized. Requests for repairs to E-mods for the vehicle must follow the same procedure as initial vehicle modification applications.

Approval Process for E-mods for a Vehicle

Step 1 The participant, Service Coordinator and anyone selected by the participant determine if any vehicle modifications are required during the development of any Service Plan.

Step 2 A VESID approved evaluator completes an assessment of the participant's needs for adaptive equipment or comprehensive vehicle modifications.

Step 3 The participant, the Service Coordinator and anyone selected by the participant must explore all other resources to pay for the modifications.

Step 4 When all other resources have been utilized, the Service Coordinator and waiver participant select a HCBS/TBI waiver approved E-mod provider.

Step 5 The E-mod provider obtains the needed bids for the modifications and selects one provider based on cost, comparability of services and professional skills.

- For modifications of less than $1,000, only one bid is required.
- For modifications of $1,000 or more, three bids are necessary.

Step 6 Bids are submitted to the Service Coordinator for selection.

Step 7 The Service Coordinator submits the request for the adaptive equipment or vehicle modification, using the Vehicle Identification and Information form and the E-mod Project Description and Cost Projection form (Appendix C-2), to the RRDS along with the Service Plan for review and approval. Information that must be submitted includes but is not limited to:

- Justification for the vehicle adaptive equipment or modification;
- All comprehensive assessments including the assessment and recommendations of the approved VESID evaluator; and
- A copy of the selected bid and the projected costs.

Step 8 The RRDS reviews the proposal and may request more information. Approval is contingent upon available funding.

Step 9 The RRDS approves the proposed E-mod for the vehicle and notifies the Service Coordinator. The Service Coordinator notifies the E-mod provider to complete the approved modifications and obtains a signed contract from the provider.

Step 10 The VESID approved evaluator who recommended the adaptive equipment and/or modifications must check work done by E-mod provider(s). The evaluator must submit a statement to the E-mod provider indicating compliance with the original recommendations before the participant picks up the vehicle. Documentation must be included verifying that the vehicle is insured and inspected by New York State following the modifications.

Step 11 The Service Coordinator submits to the RRDS: (a) the E-mod Final Cost form (Appendix C-2) and (b) the VESID statement indicating that the completed E-mod complies with the original recommendations.

Step 12 The RRDS reviews the E-mod Final Cost form and VESID statement, approves the final cost of the vehicle E-mod and notifies the Service Coordinator.

Step 13 The Service Coordinator notifies the E-mod provider to seek reimbursement.

Reimbursement

Vehicle modifications must be provided by a DOH approved provider and included in the Service Plan to be reimbursed.

Vehicle modifications will be reimbursed on a cost basis and only if the procedures described in this section have been followed. The service is reimbursed according to the final cost of the project, after approval by the RRDS.

When the E-mod provider does not complete the actual construction but is responsible for management and oversight of the project, the provider may add 10% to the actual cost of the construction for project management.

Assistive Technology Services

Definition

Assistive Technology Services supplements the State Plan Medicaid Service for Durable Medical Equipment and Supplies, which provides a broad range of special medical equipment and supplies. The Medicaid State Plan and all other resources must be utilized before considering Assistive Technology Services.

This service will only be approved when the requested equipment and supplies directly contribute to the participant's level of independence, ability to access needed supports and services in the community or maintain or improve the participant's safety.

Assistive Technology may be obtained at the time the individual becomes enrolled as a participant, no more than thirty days prior to the initial Notice of Decision, or during the development of any Service Plan. Requests for Assistive Technology must be less than $15,000 per 12 month period. Assistive Technology in the amount of $15,000 or more must be approved by DOH.

Provider Qualifications

Assistive Technology Services are purchased through vendors who sell the needed medical, communication and adaptive equipment or supplies.

Providers of Assistive Technology must be:

1. Approved by DOH under Section 504 of Title 18 NYCRR;
2. Providers to the HCBS waiver administered by OMRDD;
3. A licensed pharmacy; or
4. An approved provider of Personal Emergency Response Systems (PERS). These providers are limited to only providing PERS.

Providers of Assistive Technology must ensure that all devices and supplies meet

standards established by Underwriters Laboratory and/or comply with FCC Regulations, if appropriate.

Approval Process for Assistive Technology Services

Step 1 The participant, the Service Coordinator, and anyone selected by the participant determine if any Assistive Technology is needed during the development of any Service Plan. This must be done in conjunction with an assessment by either an ILST or other professional who is knowledgeable about the full range of options available for individuals with disabilities.

Step 2 The participant and Service Coordinator explore and utilize all possible funding sources including: private insurance; community resources; non-waiver Medicaid funding; and/or other federal/State programs. These funding sources must be accessed prior to requesting Assistive Technology Services.

Step 3 The Service Coordinator submits the Assistive Technology request to the RRDS, using the Assistive Technology Project Description and Cost Projection form (Appendix C-2) along with the Service Plan for review and approval. Information that must be submitted includes but is not limited to:

- Justification for the Assistive Technology, indicating how the specific equipment will meet the needs and goals of the participant in an efficient and cost effective manner.
- Copies of all assessments made to determine the necessary Assistive Technology, including an assessment of the participant's unique functional needs and the intended purpose and expected use of the requested Assistive Technology. The assessment must include a description of the ability of the equipment to meet the individual's needs in a cost effective manner.
- When the Assistive Technology will require modifications to the participant's residence, information must also include the name of the home owner or landlord.
- Dates of the needed Assistive Technology.

Step 4 The Service Coordinator obtains price quotes from approved Assistive Technology providers. The Service Coordinator must select an approved provider based on reasonable pricing and obtain a written price quote stating all terms and conditions of sale.

- For Assistive Technology costing up to $1,000, only one bid is required.
- For Assistive Technology costing $1,000 or more, three bids are required.

Step 5 The RRDS reviews the Assistive Technology Project Description and Cost Projection and may request more information. Approval is contingent upon available funding. The RRDS notifies the Service Coordinator of the approval.

Step 6 The Service Coordinator notifies the Assistive Technology provider.

Step 7 The Service Coordinator submits the Assistive Technology Final Cost form to the RRDS, including a detailed description of the Assistive Technology purchased and the final cost.

Step 8 The RRDS reviews the Final Cost form and notifies the Service Coordinator of the approval.

Step 9 The Service Coordinator notifies the Assistive Technology provider to seek reimbursement.

Repairs

Repairs to Assistive Technology which are cost effective may be allowed. Items that have worn out through normal everyday use (keyboards, switches, etc.) may be replaced using the same procedures that were followed to initially acquire the item. There are situations where replacement or repair will be contingent on establishing a plan that would minimize repeated loss or damage. The Service Coordinator is responsible for working with the team to develop and implement a plan to prevent repeated loss or damage.

Reimbursement

Assistive Technology must be provided by a DOH approved provider and included in the Service Plan to be reimbursed.

Assistive Technology is reimbursed based on the lowest of two costs: wholesale plus 50% or the retail cost. Repairs and replacement of parts are reimbursed at the retail cost. Assistive Technology obtained no more than thirty days prior to the initial Notice of Decision are reimbursed after the Notice of Decision is issued.

Waiver **Transportation**

Definition

Waiver transportation supplements transportation provided by the Medicaid State Plan. It includes transportation for non-medical activities which support the participant's integration into the community.

All other options for transportation, such as informal supports, community services and public transportation, must be explored and utilized prior to requesting waiver transportation. Use of this service must be indicated in the Service Plan.

Provider Qualifications

A provider of transportation under the HCBS/TBI waiver must be an:

(a) Approved provider of Medicaid State Plan transportation. Waiver transportation providers must also be approved by DOH waiver staff.

(b) Individual waiver transportation provider. Individual waiver transportation providers must:

- Have a current New York State drivers license;
- Drive a New York State registered, inspected and insured vehicle; and
- Be identified in the Service Plan.

Approval Process and Record Keeping for HCBS/TBI Waiver Transportation

(A) For approved waiver providers who are also approved for Medicaid State Plan transportation:

- The type and amount of waiver transportation must be included in the approved Service Plan.

- The participant selects the waiver transportation provider. If necessary, the advocate or Service Coordinator may request the service.

- The Service Coordinator arranges for the transportation through the local department of social services (LDSS). In New York City, the New York City Transportation Prior Approval unit must be contacted.

- After the transportation is provided, the provider bills the Medicaid Program.

- The Service Coordinator maintains complete records including dates of transportation, destination, cost and reason for using waiver transportation.

(B) For individual waiver transportation providers:

- The participant selects the individual(s) to provide waiver transportation.

The participant and Service Coordinator determine the destination and frequency of transportation.

- The Service Coordinator calls the LDSS or authorizing agency for authorization of the transportation.

- After the transportation is provided, the provider reports mileage and tolls to the Service Coordinator.

- The Service Coordinator completes a voucher received from the LDSS or authorizing agency and returns it to the appropriate party.

- The LDSS or authorizing agency processes the voucher and reimburses the waiver provider.

- The Service Coordinator maintains complete records, including the dates of transportation, destination, cost and reason for the waiver transportation.

Reimbursement

Transportation services must be provided by a DOH approved provider and included in the Service Plan to be reimbursed.

Approved providers of Medicaid State Plan transportation which provide HCBS/TBI waiver transportation are reimbursed at the Medicaid rate.

Individual waiver transportation providers are reimbursed at the private vehicle reimbursement rate established by the LDSS.

Community Transitional Services (CTS)

Definition

Community Transitional Services (CTS) provide funding for the reasonable costs of one-time set-up expenses for individuals transitioning from a nursing home to their own home or apartment in the community. Reasonable costs are defined as necessary expenses for an individual to establish his/her living space.

These services must be included in the Initial Service Plan and may not exceed $3,000, including the 10% administrative fee payable to the CTS provider. CTS assistance must be accessed by eligible individuals prior to applying for a rental subsidy and/or housing supports from the TBI Housing Program.

Items eligible for CTS funding include reasonable costs for some or all of the following items:

- Security deposits that are required to obtain a lease on an apartment or home within Fair Market Rate as established by the federal Department of Housing and Urban Development (HUD)
- Essential furnishings: bed, table, chairs, eating utensils, window coverings
- One-time set up fees for services access including: electric, heat, telephone
- Broker fee
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy
- Moving expenses

Items not eligible for CTS funding include but are not limited to:

- Televisions, cable TV access, VCRs, music systems
- Air conditioners - if medically necessary these must be applied for as an Environmental Modification (E-mod) using the procedure outlined in this Manual
- Any items which are not necessary for establishing a living space
- Monthly rent

Provider Qualifications

All CTS providers must be approved providers of Service Coordination in the HCBS/TBI waiver. However, CTS must be available to waiver participants independent of their Service Coordination provider.

Approval Process for CTS

Step 1 The individual, Service Coordinator, and anyone selected by the participant, determine if any CTS are required prior to discharge from the nursing home into the community.

Step 2 A comprehensive list of the items needed and anticipated costs is developed.

Step 3 The individual and Service Coordinator explore all possible resources including informal supports and community resources.

Step 4 After all other resources are utilized, the Service Coordinator compiles a detailed list of items and anticipated expenses using the CTS Project Description and Cost Projection form (Appendix C-2) and submits it with the Initial Service Plan to the RRDS.

Step 5 The RRDS reviews and approves the costs detailed for CTS.

Step 6 The Service Coordinator and individual select an approved CTS provider. Approved costs may be covered by CTS up to sixty days prior to the individual's discharge into the community.

Step 7 The RRDS notifies the Service Coordinator of approval for CTS.

Step 8 The CTS provider makes the approved payment directly to the broker, utility company and/or the landlord for a security deposit. Funds for essential furnishings are forwarded to the Service Coordination Agency.

Step 9 The Service Coordinator and the individual purchase the approved essential furnishings with prior approval by the RRDS. All receipts and any remaining balance must be returned to the CTS provider.

Step 10 As soon as the individual becomes a waiver participant, the Service Coordinator informs the CTS provider to seek reimbursement.

Reimbursement

Community Transitional Services must be provided by a DOH approved provider and included in the Initial Service Plan to be reimbursed.

This Service is reimbursed on a cost basis. Total one-time reimbursement for CTS must not exceed $3,000, which may include a 10% administrative fee payable to the CTS provider.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (TBI)

NOTICE OF DECISION AUTHORIZATION

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury (TBI) has been:

AUTHORIZED effective on _____. The services you are authorized to receive are identified in your Service Plan and will be reassessed at least every six months.

The law that allow us to do this is Section 1915(c) of the Social Security Act.

_____ _____
Regional Resource Development Specialist Print Name

_____ _____
Address Telephone

_____
Address

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE FRONT AND BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, you will receive a new Notice of Decision. You may ask for a conference by calling or writing to the RRDS at the telephone number and address listed on the first page of this notice. ***This is not the way to request a* FAIR HEARING.** If you ask for a conference, you are still entitled to a Fair Hearing. Read page 2 for Fair Hearing information.

cc: Guardian
Authorized Representative
Clinical Consultant
Service Coordinator
NYS DOH TBI Waiver Program
Social Services District with fiscal responsibility
Social Services District of residence (If different from county of fiscal responsibility)

RIGHT TO A Fair Hearing: If you believe that the above action is wrong, you may request a State Fair Hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING
If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend, or other person or represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society of other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyer."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (TBI)

NOTICE OF DECISION
DENIAL OF THE WAIVER PROGRAM

Name & Address of Waiver Applicant:

Client Identification Number (CIN): _____

Notice Date: _____

This is to inform you that your application for participation in the Home and Community-Based Services Medicaid Waiver for individuals with a traumatic brain injury (TBI) has been **DENIED.**

Your participation in the waiver has been **DENIED** for the following reason(s):

_____

_____

The law that allows us to do this is Section 1915(c) of the Social Security Act.

_____ _____
Regional Resource Development Specialist Print Name

_____ _____
Address Telephone

_____
Address

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Authorized Representative
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Social Services District in county of residence (If different from county of fiscal responsibility)

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☐ I want a fair hearing. The decision is wrong because: _____

_____

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INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (TBI)

NOTICE OF INTENT TO DISCONTINUE FROM THE WAIVER PROGRAM

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____ Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury (TBI) is being **DISCONTINUED** as of the Effective Date above.

Your participation in the waiver is being **DISCONTINUED** for the following reason(s):

☐ You are determined to no longer be eligible for nursing home level of care, per Patient Review Instrument and SCREEN.

☐ Waiver services cannot safely maintain you in the community.

☐ You do not have a current service plan.

☐ Other _____

Explanation: _____

_____

_____

_____

The law that allows us to do this is Section 1915(c) of the Social Security Act.

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_____
Regional Resource Development Specialist (RRDS)

_____
Address

_____
Address

_____
Print Name

_____
Telephone

cc: Guardian
Authorized Representative
Clinical Consultant
Service Coordinator
NYS DOH TBI Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

TBI Waiver
Discontinuance of Waiver Program
Effective Date_____

RIGHT TO CONFERENCE: You may have a conference to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the Regional Resource Development Specialist (RRDS) discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits).

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1. **Telephone:** You may call the statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

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   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City participants ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because: _____

_____

CONTINUING YOUR BENEFITS: If you request a fair hearing before the Effective Date stated on the front page of this Notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, New York State may recover the cost of any Medical Assistance benefits that you should not have received.

If you do NOT want your aid to continue while waiting for the decision of the fair hearing, check the box below and send this page to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201.

☐ I do NOT want my aid to continue while waiting for the decision of the fair hearing. I understand if I lose the fair hearing I may be responsible for the cost of any Medical Assistance benefits that the fair hearing determines I should not have received.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (TBI)

NOTICE OF INTENT TO DISCONTINUE FROM THE WAIVER PROGRAM

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____ Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury (TBI) is being **DISCONTINUED** as of the Effective Date above.

Your participation in the waiver is being **DISCONTINUED** for the following reason(s):

☐ You have chosen to no longer receive waiver services(s)

Explanation: _____

_____

The law that allows us to do this is Section 1915(c) of the Social Security Act.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE REST OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (RRDS) Print Name

_____ _____
Address Telephone

_____
Address

cc: Guardian
Authorized Representative
Clinical Consultant
Service Coordinator
NYS DOH TBI Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

TBI Waiver
Discontinuance of Waiver Program
Choose No Longer to Receive Waiver Services (Adequate)
Effective Date_____

RIGHT TO CONFERENCE: You may have a conference to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the Regional Resource Development Specialist (RRDS) discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

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☐ I want a fair hearing. The decision is wrong because: _____

_____

CONTINUING YOUR BENEFITS: If you request a fair hearing within 10 days of the mailing date of this notice you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, New York State may recover the cost of any Medical Assistance benefits that you should not have received.

If you do NOT want your aid to continue while waiting for the decision of the fair hearing, check the box below and send this page to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201.

☐ I do NOT want my aid to continue while waiting for the decision of the fair hearing. I understand if I lose the fair hearing I may be responsible for the cost of any Medical Assistance benefits that the fair hearing determines I should not have received.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

TBI Waiver
Discontinuance of Waiver Program
Choose No Longer to Receive Waiver Services (Adequate)
Effective Date_____

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Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (TBI)

NOTICE OF DECISION
DENIAL OF A WAIVER SERVICE

Name & Address of Waiver Applicant:	Client Identification Number (CIN): _____ Notice Date: _____

This is to inform you that your application for _____ waiver service has been **DENIED.**

Your application has been **DENIED** for the following reason(s):

_____

_____

The law that allows us to do this is Section 1915(c) of the Social Security Act.

_____ _____
Regional Resource Development Specialist Print Name

_____ _____
Address Telephone

_____
Address

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Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (TBI)

NOTIFICATION OF DEATH OF A WAIVER PARTICIPANT TO LOCAL DEPARTMENT OF SOCIAL SERVICES

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____

This is to inform you that the individual name above is discontinued from the TBI waiver program due to the death of the waiver participant on _____.
(date)

_____
Regional Resource Development Specialist (RRDS)

_____
Print Name

_____
Address

_____
Telephone

cc: Clinical Consultant
Service Coordinator
NYS DOH TBI Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF MEDICAID MANAGEMENT

Traumatic Brain Injury Initiatives

Rental Subsidy and Housing Support Program

The Traumatic Brain Injury (TBI) Housing Program provides a rental subsidy and housing supports to eligible individuals participating in the Home or Community Based Services (HCBS) TBI Medicaid Waiver. This support is designed to:

- Provide a variety of housing options for individuals with TBI;
- Assist eligible individuals to obtain accessible, affordable housing within the Fair Market Rate (FMR) established by Housing and Urban Development (HUD); and
- Provide integrated, independent living opportunities for individuals with TBI.

Eligibility Requirements

This limited funding resource is available statewide. To be eligible for a rent or utility subsidy and/or housing supports an individual must:

Be a participant in the TBI Medicaid waiver program in accordance with a current service plan, and

Fully disclose all available financial resources including Supplemental Needs Trust income; and notify the Service Coordinator immediately of any changes in their financial status, and

Apply for , and maintain an active application for all available public housing moneys, including HUD Section 8 rental subsidies; and

Be assessed as financially unable to obtain and/or maintain fair market value housing in the community without a rental subsidy;

Contribute one-third of his/ her total monthly income towards the cost of the rent. The Department of Health pays the remainder of the rental cost directly to the landlord.

Sign, agree to and adhere to all conditions specified in the Waiver Participant Contract for a Rental Subsidy.

Housing supports cover items necessary for the waiver participant to occupy a residence. This may include furniture, bedding, kitchens supplies, and various basic household items. Funding is not available for construction or capital projects. Housing supports are a one-time subsidy with a budget cap.

All requests for a subsidy or housing supports must be prior approved by the Regional Resource Development Specialist (RRDS). Expenditures which are not prior approved will not be funded.

Failure to comply with any conditions of the Waiver Participant Contract for a Rental Subsidy may result in loss of the TBI Housing Program subsidy. .

For more information, contact the TBI Housing Program at 518-474-6580.

NEW YORK STATE DEPARTMENT OF HEALTH

Excerpts

TRAUMATIC BRAIN INJURY

HOUSING PROGRAM GUIDELINES
and
APPLICATION PACKET

May 2003

Including:

Appendix E New and Revised Policy April 2003- March 2004
Appendix F New and Revised Policy April 2004- March 2005
Appendix G New and Revised Policy April 2005– March 2006
Appendix H New and Revised Policy April 2006- March 2007

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TBI HOUSING PROGRAM GUIDELINES

I. Introduction

This booklet offers guidance to service coordinators, Regional Resource Development Specialists (RRDS) and others who help people with traumatic brain injury (TBI) receive rental subsidies and/or housing support funds as part of the Department of Health TBI Housing Program. Only people served by the DOH Home and Community-Based Services for individuals with Traumatic Brain Injury (HCBS/TBI) Medicaid Waiver are eligible for these benefits.

Each HCBS/TBI waiver participant has unique housing needs. Some individuals come to the waiver after lengthy stays in either out-of-state or in state nursing homes. They may or may not have informal supports in their former home communities. These individuals may require special housing needs, as well as assistance in making informed choices. Other individuals may come to the waiver directly from living in the community. They may or may not need rental subsidies, housing support funds, or assistance in locating an apartment, depending on the level of informal supports and comfort with their current housing.

The TBI Housing Program is primarily a rental subsidy program, based on federal Housing and Urban Development (HUD) fair market rent (FMR) costs. However, if an individual chooses to stay in his/her own home, but needs financial assistance to do so, the TBI Housing Program may provide assistance, such as payment of utilities. The TBI Program does not enter into mortgage agreements with banks or financial organizations on behalf of a waiver participant. However, every effort would be made, if requested, to assist an individual in finding available HUD or housing finance programs that might provide mortgage loan assistance. The challenge is in finding ways to help each individual obtain their choice for location and type of housing within the parameters of affordable and accessible housing.

The Housing Guidelines provide information on:

- X Working with waiver participant's and families;
- X Locating generic affordable accessible housing and Housing Resources;
- X Completing the enclosed TBI Housing Application;
- X Helping individuals with TBI maintain their housing within TBI Housing Program standards; and
- X Policies of the TBI Housing Program.

Program Principles

Those assisting individuals with finding housing should keep the following principles of the TBI Housing Program in mind.

1. Individuals should have choices in their lives about where they live, with whom they live, what services they receive and who provides those services.

2. People with TBI should live in integrated, decent and accessible housing.

3. People with TBI should have a variety of housing and service options within Fair Market Rate (FMR) established by Housing and Urban Development (HUD).

4. Housing and services should be separated to allow individuals the opportunity to live as independently as possible in housing of their own choice.

5. No more than four unrelated individuals may share a single dwelling and each individual must have their own bedroom with adequate space.

These principles are to ensure that waiver participants have the opportunity to live in non-institutionalized settings with as much choice as possible.

Availability of Funding

Rental subsidies and housing support funds, and assistance with utility costs are available to eligible waiver participants to help them obtain accessible affordable housing of their choice within fair market rates.

This is a limited funding resource dependent on the allocation of state monies each budget year. Each Regional Resource Development Specialist (RRDS) determines which waiver participants will be eligible for housing funds based on the regional allocation of state funds and the prioritized housing needs of individuals anticipated to be candidates for services through the HCBS/TBI waiver program.

To receive rental subsidies, housing supports and assistance with utility costs, an individual must:

- Be a participant in the HCBS/TBI Medicaid Waiver who has been assessed as financially unable to obtain and maintain fair market rent housing in the community without supplemental rental subsidies;

- Disclose all available financial resources including but not limited to SSI/SSDI, Supplemental Needs Trust, Workers Compensation, Insurance settlements;

- Make application for all available public housing money, including HUD Section 8 rental subsidies;

- Contribute one-third of his/her income towards fair market rent. For wavier participants demonstrating a financial need, the NYS Department of Health (DOH) may pay the remainder of the rent directly to the landlord.

As this is a funding stream of last resort, it is to be used only for rental subsidies, housing supports and utility costs. The rent subsidy follows the individual as long as he/she is a TBI waiver participant or until the individual transitions to Section 8 public housing, other subsidies, or no longer needs rental assistance. The DOH rental subsidies are to assist individuals in meeting the costs of moderately priced affordable, accessible housing. It is not a grant to offset more expensive rental costs. Assistance with payment of utility costs for heat and electricity may be available for waiver participants depending on eligibility and funding.

Housing supports are strictly defined as those basic items needed by an individual to occupy a residence. They include: furniture, basic kitchen appliances, pots, linens and various basic household items. Housing support funds are not issued for luxury items such as designer furniture or expensive appliances. Funding is not available for construction or capital projects. Funds for housing supports are distributed by the service coordinator for the participant. (See Sect. VI Policy on Housing Support Funds).

Utility subsidy includes assistance with heat, electric, and the lowest basic phone service. It is recommended that all waiver participants establish a monthly budget plan for payment of utilities. When a need is demonstrated DOH may pay 2/3 of the budgeted amount directly to the utility company. The waiver participant is required to pay the remaining 1/3 of the budgeted utility cost and all phone charges beyond the lowest basic phone service. (See Appendix A Instructions for completing the Utility Application and Utility Policy).

Role of Regional Resource Development Specialist (RRDS)

The Regional Resource Development Specialist (RRDS) in each region is the primary resource for individuals with TBI and their families (See Appendix C).

The RRDS is responsible for managing the TBI housing funds allocated to their region and maintaining a pipeline list of individuals eligible for, or already receiving housing funds.

The RRDS can assist potential waiver participants who need housing, and service coordinators working with participants, by assessing and prioritizing the need for rental subsidies and housing supports, and determining whether an individual will be included in their yearly housing pipeline budget.

The RRDS can also provide information regarding local Housing Resources or make referrals to Residential Placement Management Services, the Department of Health TBI Housing Resource (See Appendix C).

Role of the Service Coordinator and Service Coordination Agency

In addition to completing the housing application forms, the service coordinator, under direction of the service coordination agency, helps the waiver participant assess housing and housing budget needs, locate housing and arrange payment for housing utilities and services. However, the service coordinator does not choose housing for the waiver participant. To the extent possible, the waiver participant and involved family and friends should make the housing choice. The service coordinator's role is to enable this choice to become a reality.

The service coordinator may expect to perform the following tasks:

- Assist the waiver participant with completion of applications for Section 8 and Public Housing as required by the TBI Housing Program
- Locate desirable, affordable, accessible housing of an individual's choice that meets fair market rents for housing in the region.
  (Except in NYC and the Hudson Valley regions where RPMs provides housing locating services);
- Assist with landlord interactions and negotiations, as necessary;
- Coordinate with the waiver participant to ensure that their portion of rent is paid to the landlord. The service coordination agency needs to reinforce the importance of monitoring the payment of the participant's share;
- Arrange for moving and repairs as necessary;
- Arrange for telephone and utilities;
- Assess and monitor the rental property initially and annually using the **TBI Housing Standards Checklist** (See Sect. IV Quality and Appendix B);
- Be available to assist the individual in resolving housing issues.

As previously mentioned, the service coordinator should support the waiver participant's right to choose where he/she lives and with whom. Ideally, the waiver participant will have a variety of housing and service options available.

Role of TBI Housing Resource (RPMs)

The Center for Urban Community Services (CUCS), Residential Management Placement Services (RPMs), the TBI Housing Resource, is responsible for statewide review and processing of all TBI housing applications before submission to the Payment Agent (AHRC).

Technical assistance and training is available to all RRDS and providers regarding preparation of applications, negotiations with landlords and general housing locating information. In the downstate regions of New York City and the Lower Hudson Valley RPMs is directly responsible for locating fair market housing for waiver participants.

Beginning in 2003, RPMs Quality Assurance Specialist will begin reviewing and tracking initial and annual TBI Housing Standards Checklists completed on housing subsidized by the TBI Housing Program. Technical assistance and follow-up will be provided to service coordinators as needed to resolve any identified deficiencies.

All questions regarding waiver participants' housing, landlord issues, housing locating information or completion of TBI Housing applications should be referred to RPMs (See Appendix C).

Role of TBI Housing Program Quality Assurance (QA) Specialist

The Department of Health developed housing quality assurance standards to ensure that subsidized housing is comfortable, meets the needs of the waiver participant and remains in good repair. These standards are reflected in the TBI Housing Standards Checklist. Service coordinators are required to complete the Checklist and assist the waiver participant with negotiations with landlords if necessary, to bring housing into compliance with TBI housing standards before the waiver participant takes residence. An annual review of housing using the TBI Housing Standards Checklist is required to ensure that housing continues to meet established standards.

The responsibilities of the Housing QA Specialist include:

1. Track completion of all TBI Housing Standards Checklists for housing subsidized by the TBI Housing Program statewide in accordance with TBI Housing Program Guidelines;

2. Review all Checklists to determine that housing meets minimum standards established in the TBI Housing Standards Checklist;

3. Identify possible deficiencies in housing noted on the Checklist;

4. Provide training and technical assistance to Service coordinators in completing the Checklist, identifying deficiencies and providing assistance and follow-up to resolve housing problems;

5. Communicate with the RRDSs regarding significant deficiencies in housing in their region, inform them of the plan developed between the QA specialist and the service coordinator to remedy the deficiency and advise the RRDS of the outcome;.

6. Assist with the housing location efforts in New York City; and

7. Visit a sample of housing situations in each region, throughout the state to determine compliance with TBI Housing Standards Checklist.

Role of TBI Housing Payment Agent (AHRC)

The Association for the Help of Retarded Children in New York City (AHRC of NYC) provides TBI housing Payment Agent services under contract to DOH. The Payment Agent (AHRC) is responsible for processing statewide rental, utility and housing support payments to landlords, utility companies and other payees once an application is approved by the RRDS, as the DOH designated state agent, and reviewed by RPMs, the TBI Housing Resource. AHRC (the housing Payment Agent) communicates directly with DOH and RPMs. AHRC is not available to respond directly to service coordinators, landlords, or waiver participants regarding payment issues. ***All queries regarding waiver participant, landlord, or other problems with housing payments are to be directed to RPMs, the TBI Housing Resource (See Appendix C).***

AHRC processes approvals as they are received from RPMs. It can be expected that checks will be cut within one week of the Payment Agent's receipt of the approval. Any discrepancies or problems will be communicated directly to RPMs. RPMs will, if necessary, contact the appropriate RRDS or service coordinator.

Once an initial monthly rental or utility subsidy is approved and received by AHRC, it is automatically generated each month. Monthly rental and utility subsidy payments are processed on an ongoing basis and can only be stopped or changed when a Status Change form is submitted (See Section V, and Appendix A).

AHRC begins to process ongoing monthly rental and utility subsidy payments on, or about **the 20th of each month**, prior to the month that the payment is due (i.e., July payments are processed on June 20). The payments are mailed to the payees on or about the 25th of each month. The Payment Agent provides a detailed tracking of all subsidy and housing support payments to the Department of Health on a monthly basis.

AHRC is also responsible for notifying DOH and the RRDS of any overpayments of rent and utilities or potential recoupment of security deposits. A report, which tracks all overpayments and recoupment of funds, is provided to DOH on a monthly basis.

The Payment Agent is available to assist the RRDS with writing letters requesting the return of the overpayments, but is not responsible for directly recouping overpayments. (See Section VI Policy Pertaining to Recouping Overpayments and Security Payments).

II. Working With TBI Waiver Participants

Finding out what type and location of housing the TBI Waiver participant wants often requires patience, insight and perseverance. In many cases an individual with TBI may be looking for a place to live after residing in an out-of-state or in state nursing home. In some cases, the DOH TBI rental subsidy will not enable the individual to live in circumstances they may have afforded before their brain injury. In some cases, the individual may be relocating to an unfamiliar community or neighborhood. All of these factors create challenges for the waiver participant. The service coordinator needs to be sensitive and listen carefully to assist the waiver participant in choosing housing.

Identifying Needs

Strategies for identifying needs of waiver participants:

X Be positive and proactive in contacting the waiver participants;

X Take time to establish rapport;

X Clearly state the purpose of any discussion;

X Help the waiver participant clarify housing concerns and define the precise nature of the concerns;

X Listen empathetically and be responsive to concerns;

X Establish consensus regarding the waiver participant's priority housing needs;

X Help waiver participant clarify furnishings and household goods needed;

X Ask the waiver participant to describe the ways in which he/she deals with daily routines in order to assist in determining suitable type of housing;

X Ask about hobbies, interests, what he/she considers fun in order to establish suitable housing location.

Communication Strategies

Individuals with TBI may have cognitive or other deficits that make it difficult for them to easily understand or process information you are trying to convey.

The following communication strategies for helping to guide housing choices were developed by RPMs, the TBI Housing Resource, for individuals in the TBI Housing Program in New York City and the Lower Hudson Valley.

Explore: Try to understand the significance of a stated preference. Avoid assuming that you understand a person's reasoning. Ask questions like: "Can you tell me why this is so important to you?"

Prioritize: Attempt to simplify problems by breaking down the obstacles and identifying priorities. Ask questions like: "What are the three most important things for you in order of importance?" or, "If you had to give up one of these things, which would it be?"

Educate: Before educating someone, find out how much they really know. Don't lecture, but rather fill in the gaps. Use phrases like: "Maybe I can help to clarify that for you."

Empathize: Be sensitive to issues of loss and shame. Try to listen to the feelings under the requests. Use phrases like: "I realize that this must be difficult for you."

Join the Resistance: Avoid power struggles or confrontations. Don't become invested in being right. Remember that you are on the same side and reframe the problem as shared. Use phrases like: "I just want you to make sure that you understand that you may lose both apartments if you can't come to a decision by next week."

RPMs can assist you in your efforts on behalf of waiver participants by offering further technical assistance. (See Appendix C)

III. Locating Generic Affordable Housing

The service coordinators' role is to assist the wavier participant in locating generic affordable housing that is considered typical for the community. Rental costs should reflect that community's fair market rent (FMR) as established by Housing and Urban Development (HUD) for Section 8 Housing.

Service coordinators should focus on gaining access to affordable housing by facilitating the following:

X Negotiating access to publicly or privately funded affordable housing within HUD fair market rent;

X Assisting waiver participants to apply for federal Housing and Urban Development (HUD) Section 8 housing, Rural Rental Assistance, and other rental subsidies;

X Assisting participants to secure affordable housing on the open market.

Service coordinators can receive help in locating housing from the RRDS for their region or RPMs, the TBI Housing Resource (See Appendix C). Each RRDS coordinates funding and program resources for individuals with TBI within a specific region. The RRDS may work with service coordinators to develop and maintain lists of affordable, accessible rental properties and cooperative landlords in each region. RPMs can also offer technical assistance or training about locating affordable housing.

Strategies for Finding Housing

To locate appropriate housing, service coordinators should peruse local newspaper advertisements and/or contact landlords, real estate brokers, housing coalitions, the appropriate RRDS, public housing authorities, tenant's organizations, Independent Living Centers and regional offices of the NYS Division of Housing and Community Renewal (DHCR). The RRDS can assist service coordinators in locating regional resources. RPMs can provide technical assistance and training to RRDSs and service coordinators about identifying useful housing locating strategies.

The waiver participant's living situation will affect his/her relationships with family and friends, involvement in the community, personal finances and overall satisfaction with life. Therefore, the waiver participant and the service coordinator should base their housing choice on a combination of factors that reflect what's best for the individual in question.

Considerations for Finding Generic Affordable Housing

General Location: In most instances the service system that a waiver participant depends on for support (e.g. residing in a specific county) will affect the choice of location. Some people choose to live relatively close to family and friends because they rely on these important supports. Preferences for urban, suburban, or rural living are important for many individuals. Other considerations are supportive communities, public transportation, available conveniences, etc.

Neighborhood: People tend to choose neighborhoods that offer specific features of importance to a preferred lifestyle. Many features define neighborhoods, such as, community personalities, inclusiveness/isolation, political and social tolerance/intolerance of diversity, or community activism/conservatism.

Neighborhood considerations are also important in different ways to different people. Many people are interested in what communities have to offer in the way of parks and recreation programs, churches, school, libraries, etc. Neighborhood commercial resources, such as, stores and restaurants are often important, particularly for persons for whom transportation outside the neighborhood may be difficult and time consuming. Finally, a waiver participant will want to consider the environment he/she prefers, such as, lakes, trees, space, quiet or the bustle of an urban neighborhood.

Nearby Resources: Many individuals must be near certain specific resources. For example, people without personal transportation may wish to be close to grocery stores and community resources that are used on a frequent basis. Access to public transportation may be important. For people with physical disabilities or people who may become disoriented, and for whom traffic may pose a threat, specific paths of community access may need to be determined.

Housing Features: It is important for the waiver participant and service coordinator to assess the specific house or apartment for features such as physical accessibility, attractiveness, and affordability. **The TBI Housing Standards Checklist** has been included to assist in assessing the housing choice (See Section IV and Appendix B).

IV. Quality Assurance & Maintaining Housing

Quality Assurance Standards and Use of TBI Housing Standards Checklist

The Department of Health has developed housing quality assurance standards which are reflected in the **TBI Housing Standards Checklist** (See Appendix B) to assist waiver participants in securing affordable accessible housing that is comfortable, in good repair and meets the minimum standards determined by the TBI Housing Standards Checklist.

All subsidized housing is assessed using the TBI Housing Standards Checklist before a waiver participant begins residence. Housing deficiencies are to be remedied before the waiver participant takes occupancy. The consumer satisfaction part of the checklist is done with the waiver participant within three months of the move-in date.

The service coordination agency is responsible for training the service coordinator on the completion of the housing application, including the TBI Housing Standards Checklist. RPMs can provide technical assistance on the completion of the TBI Housing Program application and forms.

Housing is to be assessed by the service coordinator on an annual basis in conjunction with the review of the individual service plan. The annual assessment using the TBI Housing Standards Checklist must be maintained in the waiver participant's file and a copy forwarded to RPMs Quality Assurance (QA) Specialist. The QA Specialist will review all Checklists, provide technical assistance to service coordinators and monitor follow-up on corrective action to address any deficiencies.

If at any time a service coordinator notes a potentially serious housing deficiency or situations that do not meet the TBI Housing Standards, and the landlord refuses to make necessary repairs in a timely manner, this must be immediately brought to the attention of RPMs QA Specialist, and the RRDS. The waiver participant should be assisted in relocation to other affordable and suitable housing as soon as possible. If a service coordinator has questions, RPMs is available to provide technical assistance on housing quality assurance issues. All concerns about housing deficiencies are to be stated in writing to the RRDS and copied to RPMs. A copy of the **TBI Housing Standards Checklist** describing the deficiencies noted in the housing should be placed in the waiver participant's file as well as a new **TBI Housing Standards Checklist** describing the newly selected housing.

Apartment or House Move-in

Maintaining housing begins as soon as an apartment has been selected. Before a single piece of furniture is delivered, the service coordinator must make sure that the apartment is in "move-in" condition. The following tips will help the waiver participant with the move-in and ongoing maintenance of their new home. The TBI Housing Standards Checklist will assist in assessing and maintaining good housing.

Apartment Check: Check toilets, windows, locks, smoke detectors, faucets, outlets, paint job, floors, appliances, etc. to make sure that everything is in working order. Talk to the superintendent or building maintenance office before taking problems to the landlord. A goal for the service coordinator, when possible, is to make friends with the building staff. Let the building maintenance office know what needs to be done immediately and give a reasonable amount of time to accomplish these tasks. RPMs may be contacted for technical assistance, if necessary.

Finding Furniture: Tap all social support networks for resources. Try to get furniture and housewares donated before purchasing items. Arrange for furniture delivery, cable or other utility hook-ups on the same day so that you won't waste large amounts of time waiting for deliveries and service people.

Phone Service: Determine where jacks should be installed, if necessary. **The TBI Housing Program may subsidize only the lowest basic phone service**. Some waiver participants may be eligible for an emergency response system that is covered by Medicaid as special medical equipment.

Electricity: If the previous tenant left with unpaid bills, you may need a letter of occupancy for the apartment from the landlord to get the power turned on.

Heat and Fuel: To get gas turned on or heat delivered, an account needs to be established with the gas or fuel company. All waiver participants who need assistance with payment of heat or fuel bills are to apply for HEAP assistance before requesting a TBI subsidy.

Cable Television: The TBI Housing program does not subsidize Cable television service. The waiver participant would have to assume these costs.

Special Home Adaptations: If necessary, home adaptations may include: gas/timer device to shut off gas, unplugged electric stove, a temperature gauge on the hot water to prevent scalding (if the waiver participant has lack of sensitivity to heat/cold), fire gates on windows, grab bars and a timer for sinks, tub and shower. Many of these adaptations may be covered under Medicaid or Environmental Modifications through the HCBS/TBI waiver.

Services: Services must be in place prior to move-in. Make sure that emergency plans are in place, including:

- X Evacuation procedure;
- X What to do in case tenant becomes locked out;
- X Location of closest hospital emergency room;
- X List of emergency phone numbers in an accessible place;
- X Transportation arrangements are complete and understood by the waiver participant and
- X What the waiver participant should do if a home attendant doesn't arrive.

In cases where the waiver participant will not have 24-hour assistance, assess whether a medical alert system is necessary.

Bill Payment: It is the responsibility of the service coordinator to develop a payment plan with the waiver participant to determine how they will pay their portion of the rent and who will ensure that payment is made. The service coordinator should monitor adherence to the plan on a regular basis. Some individuals may require a representative-payee.

V. Completing TBI Housing Application Forms

Overview of Housing System and Application Procedures

The DOH TBI Housing Program has been established to assist individuals who participate in the HCBS/TBI waiver to meet their housing needs. These needs can include choosing, locating, and paying for affordable, accessible housing. A system is in place to ensure that good quality affordable rental housing is located, assessed, and secured as efficiently as possible. To facilitate this process, there are defined roles for service coordinators, RRDSs, RPMs, the TBI Housing Resource, AHRC, the TBI Payment Agent, and the waiver participant.

The following components of the TBI Housing Program application/payment process are to provide checks and balances to ensure the delivery of high quality and cost effective rental subsidies and housing supports to eligible waiver participants:

- Service coordinators are responsible for completing TBI housing applications in accordance with the application instructions for all regions (except New York City and Hudson Valley RRDS regions). RPMs completes the *initial* housing applications for rent or utility subsidies in New York City and the Hudson Valley RRDS regions. The service coordinator completes follow-up housing application transactions for these regions;

- Completed TBI housing applications will be signed by the service coordinator, the RRDS, and RPMs the TBI Housing Resource;

- Wavier participant's or their representative will sign the Narrative portion of the TBI Housing application;

- RRDS will be responsible for ensuring that each application represents an individual designated as needing housing in his/her region, and that there is sufficient funding in the state fiscal year housing allocation to cover the projected rental subsidy and housing support costs for that individual;

- RPMs, the TBI Housing Resource, will be responsible for accurately performing final housing application reviews and submitting housing applications to the Payment Agent. RPMs will provide technical assistance to the RRDSs and service coordinators in completing applications or locating housing;

- AHRC, the TBI Payment Agent, will be responsible for ensuring that signatures of RRDSs and RPMs are listed on the application before issuing checks. Payments are mailed on or about the 25th of each month. *AHRC will not process checks if the required signatures are missing.*

Housing Application Forms and Instructions

The following application forms and instructions are to be utilized when an individual needs a housing subsidy, housing support, utilities, or is moving to another rental unit or terminating current housing. The regional RRDS and RPMs (See Appendix C) can assist in answering questions about completing the application forms. All forms completed by a service coordinator are submitted to the RRDS who reviews and then forwards to RPMs, the TBI Housing Resource, for technical review. RPMs forwards accurate and complete applications to AHRC, the TBI Payment Agent, for payment.

The instructions for completing the various housing forms are included in the TBI Housing Application Packet (See Appendix A).

A **NEW YORK STATE DEPARTMENT OF HEALTH TBI HOUSING APPLICATION PACKET** may include:

1. INDIVIDUALHOUSING AND HOUSING SUPPORT NARRATIVE:
   To determine need for rental subsidy or housing supports
2. APPLICATION
3. PAYMENT REQUEST
4. HOUSING SUPPORT ADDENDUM and ACTUAL EXPENDITURES
5. UTILITY APPLICATION
6. STATUS CHANGE FORMS for changes in Rent and Utilities
7. CONSUMER AGREEMENT

1. INDIVIDUAL HOUSING AND HOUSING SUPPORT NARRATIVE

This document provides RPMs, the TBI Housing Resource, with important necessary information in reviewing and processing the various components of the housing application. It is for the purpose of providing an explanation or details about the application request. The housing Narrative form must be submitted with all requests for subsidies or supports.

2. INITIAL APPLICATION

When a waiver participant makes an initial application it is important to provide complete and accurate information. The information on the application directs the Payment Agent as to the amount of the payment and to whom the check should be issued. RPMs, the TBI Housing Resource, reviews each application before forwarding to the Payment Agent to insure it is accurate and complete. A copy of the initial housing application and all subsequent application requests are filed in the waiver participant's files and maintained by the service coordinator.

3. PAYMENT REQUEST

A Payment Request provides information to the Payment Agent about one-time costs such as household goods, security deposits, or other single payment items. If utilized for a new housing participant it would be accompanied with a completed Narrative and initial application. If submitted for a participant already in the system it should be submitted with just the housing Narrative form.

4. HOUSING SUPPORT ADDENDUM and HOUSEHOLD GOODS ACTUAL EXPENDITURES

The Housing Support Addendum is a list household items developed by the waiver participant assisted by the service coordinator. All other sources for obtaining these items should be explored before submitting this list to RRDS for approval. An accounting of purchases made and the actual cost is documented on the Household Goods Actual Expenditures form.

The maximum amount paid for household goods is $1,200 for a waiver participant living in the community, and $1,600 for an individual who has been residing in a nursing home for a number of years and has no available household goods. These amounts may be revised periodically, dependent on cost of living or program budget.

- An itemized list of items to be purchased must be submitted on the Housing Support Addendum.

- The service coordinator must maintain all original receipts in the waiver participants' file (See section VI Policy for Housing Support Funds).

5. UTILITY APPLICATION

The utility application provides information to AHRC, the Payment Agent, about monthly payments to utility companies. If utilized for a new housing participant it would be accompanied with a housing Narrative and initial Application forms. If submitted for a participant already in the system it may be submitted with just the Narrative.

- A copy of the utility company payment stub that clearly includes the account number must accompany all applications for utilities.

- Any change in a utility account number or subsidy amount must include a copy of the utility company payment stub with the Utility Status Change form. A copy is NOT needed for a STOP utility.

- Only basic telephone service is paid by TBI housing funds, the waiver participant pays all other phone services.

6. STATUS CHANGE FORMS

Status Change forms direct the Payment Agent to immediately STOP or CHANGE a monthly payment. These forms are used when a waiver participant leaves the program, changes or stops a rental subsidy, or, changes or stops a utility subsidy. **It is important to submit the Status Change form to RPMs, the TBI Housing Resource, as soon as possible to avoid an overpayment.** When overpayments occur it is the responsibility of the RRDS to recoup the overpayments with assistance from AHRC and RPMs.

7. CONSUMER AGREEMENT

The Consumer Agreement provides an opportunity for the waiver participant to agree to abide by the basic expectations of tenancy for landlords and tenants under the DOH TBI Housing Program.

VI. TBI Housing Policies
Policies Pertaining to Waiver Participants

Participant Living With His/Her Family or Unrelated Individuals

Waiver participants living alone generally live in one-bedroom apartments and contribute one-third of their income towards rent. The TBI rental subsidy pays the remainder of the fair market rent directly to the landlord or designated payee. **In order to receive a TBI housing subsidy financial need must be established.** When an individual lives with other co-payers the cost of his/her rent may be reduced to a level that does not require a rental subsidy.

When a waiver participant and spouse live in a house owned by the spouse, the SSI of the participant usually covers his/her housing costs; he/she is not usually eligible for a TBI rental subsidy. This is primarily a rental subsidy program. It is not intended to buy homes for individuals and their families, and as such does not pay mortgages. However, when possible, the RRDS and RPMs will try to find resources to assist homeowners, such as partial payment for utilities and household items. They may also refer individuals to other housing resources in their communities, such as, public housing authorities or HUD lenders, that can provide additional assistance.

The TBI Housing Program recognizes that individuals living with families need to have their housing considered within this context. If the TBI Housing Program participant has a family, and they mutually agree to maintain a rental unit together, the following requirements are applicable.

1. The living areas and number of bedrooms should be adequate for the comfort, privacy and safety needs of the family members, and be within the parameters of fair market rent for affordable accessible housing stock as established by HUD for Section 8 Housing.

2. All adult family members (i.e. over the age of eighteen unless a full-time student under the age of 25) are required to pay their fair share of the rent. If other family members receive public assistance, they would contribute their fair share towards the cost of rent. The TBI Housing Program may or may not support the portion of the rent required for the individual with TBI living in a family situation. There may be instances when the individual's SSA or SSDI income is sufficient to cover housing costs without the addition of a TBI rental subsidy.

3. Income received for children in the family, such as SSA benefits, that includes costs for housing, needs to be considered as part of the total family income.

If the waiver participant chooses to live with family or unrelated individuals the following requirements are applicable.

1. The landlord should be notified of any changes in tenancy or the lease agreement.

2. If related or unrelated persons choose to live with waiver participants receiving rental subsidies or housing supports, they are expected to pay their fair share of the rent, and the waiver participant's support will be reduced accordingly.

3. If a person or persons move into a waiver participant's apartment after rental subsidies/housing supports have been determined, the apartment space should be reassessed for meeting the participant's comfort and privacy needs; the rent share will be reconfigured to reflect the wavier participant's fair share of the rent.

Numbers of Unrelated Individuals Living Together and Number of Bedrooms in a Home

The principles of the TBI Housing Program include supporting the kinds of environments that allow maximum choice and independence for each individual. Because of this, it is the intention of the housing program **to limit housing to a maximum of four unrelated individuals per unit dwelling, and to stipulate that each of these individuals has his/her own separate bedroom.** This policy was established to ensure the TBI housing standards for generic affordable housing could be met by conventional landlords. It was also developed to meet the requirements for least restrictive setting promoting maximum independence under the Medicaid guidelines for Home and Community Based Services Medicaid Waivers.

1. For non-related individuals living together, the number of bedrooms cannot exceed four bedrooms per unit dwelling. The living areas and bedrooms must be adequate for the comfort, privacy and safety needs of all individuals.

2. No more than four individuals can occupy a four-bedroom unit. Each individual must have his/her own bedroom. Providers and landlords cannot "double bunk" waiver participants. Married couples or significant others may choose to share a bedroom.

Participants Evicted from Housing or Terminated From the TBI Housing Program

A primary goal of the TBI Housing Program is to assist waiver participants in maintaining the responsibilities of tenancy in their selected housing. Each individual is requested, as part of the housing application, to sign an agreement delineating his/ her responsibilities and rights as a tenant. The service coordinator reviews and signs the Consumer Agreement (See Appendix A). In some cases, this basic agreement is modified to include individual specific items pertaining to particular areas that have been problematic for a waiver participant, such as noise, illegal drug activity, non-paying illegal co-habitors, or former lease infractions. The service coordinator, with RPMs technical assistance if necessary, may occasionally need to advocate for a waiver participant or negotiate with the landlord to resolve tenancy problems.

However, if an individual is evicted from an apartment the service coordinator is responsible to assist the individual in relocating to another apartment (except in the Lower Hudson and New York City where RPMs is the housing locator. **This may require two Status Change forms. One to STOP the rental subsidy at the old address and one to START rent to the new landlord.**

If an individual is unable to remain a HCBS/TBI waiver participant, they become ineligible for rental subsidies or housing supports. If this is a temporary situation, for example the individual returns to a nursing home or enters inpatient rehabilitation, the RRDS and service coordinator may wish to continue the rental subsidy to hold the apartment for up to three months while evaluating the final disposition for the individual. However, once a waiver participant receives a notice of waiver termination the rental subsidy will be terminated within 30 days.

It is the responsibility of the service coordinator to notify the landlord immediately in writing that the individual will be terminated from the waiver program and the date when the DOH rental subsidy will be discontinued.

Policies Pertaining to Payment Issues

Recouping Overpayments and Security Deposits

The RRDS agencies and service coordinators are responsible and accountable for prudent spending and monitoring of the allocated TBI housing funds. All overpayments and security deposits to landlords and utility companies need to be recouped. AHRC, RRDS and RPMs will assist service coordinators in this process. The RRDS is responsible for the recoupment of overpayments of rental subsidies, utility subsidies and security deposits paid by DOH on behalf of participants in the TBI Housing Program.

The following steps occur anytime there was an overpayment because of late receipt of a Status Change form or the need to collect a Security Deposit because a waiver participant moved from an apartment.

- AHRC, the TBI Payment Agent, will initiate a draft letter to the payee (individual, landlord, company or utility in receipt of overpayment or security deposit) requesting the return of the payment;

- AHRC will forward the draft letter to the RRDS for his/her review (A copy is forwarded to RPMs);

  Regarding overpayments

  The RRDS is responsible for determining if an overpayment *actually* has occurred and *if* it is collectable. If it is determined that a refund is collectable, the RRDS will forward the AHRC letter to the payee and notify AHRC via e-mail (with a copy to RPMs) regarding the status of the letter and the overpayment (i.e. is the overpayment collectable and has the letter been forwarded to the payee);

  Regarding Security Deposits

  DOH understands that there may be circumstances that warrant the retaining of a security deposit by a landlord. The RRDS is the only person with this information and is therefore responsible to determine if the security deposit should be returned. If the RRDS determines that the security deposit should be returned, the RRDS will forward the AHRC letter to the payee;

- If, after six weeks from the date of the initial AHRC recoupment letter, the overpayment or security deposit has not been received by AHRC, RPMs will contact the RRDS to gather more facts about the situation and assess whether recoupment is a viable option;

- If RRDS indicates to RPMs that pursuit of recoupment is warranted, RPMs will generate a letter to the payee stating the responsibility of the payee to return the overpayment of Department of Health funds; a copy of the letter is forwarded to the RRDS and AHRC;

- If after ten days from the date of the RPMs letter to the payee, the money has not been returned to AHRC or the payee has not contacted RPMs, as directed in the letter, then RPMs will phone the payee and initiate a dialogue concerning the overpayment;

- RPMs will report the outcome of this phone conversation to the RRDS. If the RRDS feels that recoupment is still possible, then RPMs in conjunction with RRDS will develop a further strategy for recoupment. If the RRDS feels that no further action should take place, he/she will advise RPMs who will advise AHRC that the case is "closed;"

- DOH TBI Housing Program may request assistance from DOH legal counsel when appropriate;

- If and when an overpayment is returned to AHRC, AHRC will e-mail the RRDS and RPMs as notification that the overpayment or security deposit has been received;

- The amount recouped is returned to the RRDS budget as a "Refund;"

- AHRC will maintain a tracking by region, of all overpayments and security deposits due and received. The report will be sent to DOH TBI Housing Program and RPMs on a quarterly basis.
  DOH will share this information with the RRDS;

- In the case of overpayments due to Payment Agent error, AHRC will be responsible for following up on the overpayments and letters sent to the payees. The Payment Agent may need to communicate with the RRDS to determine how to address the specific situation.

Rent Arrears by waiver participant or non-waiver individual sharing dwelling

There may be occasions when the landlord needs to resolve an issue of non-payment of rent. Most frequently, this happens because the participant, or a roommate living with the participant, neglects to pay their rent share.

To avoid this situation, the service coordinator (sometimes assisted by the Independent Living Skills Trainer) should review the rent due bill on a periodic basis with the waiver participant to ensure there are no rent arrears.

If there are rent arrears, the service coordinator must assist the waiver participant in making arrangements for back payment. The service coordinator should also inform the RRDS that there is a rent payment problem so they are aware that this waiver participant's housing is in jeopardy. Failure on the part of the waiver participant to pay their portion of the rent may result in the termination of housing subsidy funds in accordance with the Consumer Agreement signed by the waiver participant.

If a non-waiver individual living with a waiver participant is in arrears on his/her portion of the rent, the individual will be notified by the service coordinator that they must either meet the terms of the lease or vacate the apartment. The service coordinator should notify the RRDS.

Housing Support Funds

When a need is demonstrated, the HCBS/TBI Housing Support Program may provide financial assistance to procure necessary household goods for waiver participants through the use of Housing Support Funds. Household goods may include pots and pans, cooking utensils, dishes, towels and sheets, lamps, microwave, and basic furniture bed, couch, chairs, dinning set and also includes moving expenses.

Housing Support Funds are a one-time allocation intended to assist the waiver participant with household items needed to move from a facility into the community. It is funding of last resort. Other resources such as Supplement Needs Trusts, family and community agencies should be explored before requesting Housing Support Funds.

There may be some situations where the individual has been in the HCBS/TBI waiver for more than 5 years and replacement of some items is necessary. These requests are reviewed on a case-by-case basis.

Maximum limits
Waiver participants are eligible for a maximum of $1,200 if already living in the community and $1,600 if moving from an institution.

Obtaining funding for Housing Supports

Preferably, the service-coordinating agency should assist the waiver participant in obtaining the necessary household goods and submit copies of all receipts payable to the agency for reimbursement with the Housing Support application.

Household goods may be purchased from local stores and placed on layaway. A copy of the itemized list and costs should be submitted with the Housing Support Application. Checks for approved purchases will then be issued directly to the store.

Occasionally, it is necessary to obtain housing support funds prior to the purchase of the items. A list of all items and their cost must be submitted with the Housing Support Application to RRDS for approval. The application is then forwarded to RPMs and AHRC for processing. The advanced funds will be issued to the service-coordinating agency. It is the responsibility of the service-coordinating agency to obtain receipts for ALL items purchased.

Responsibilities of the service-coordinating agency

1. The service-coordinating agency is responsible and accountable for prudent spending and monitoring of allocated TBI Housing funds.

2. The service-coordinating agency assists the waiver participant in the development of a list of household goods to be purchased using Housing Support funds. The service coordinator is expected to assist the waiver participant in the best use of their funds through the use of second hand stores, discount stores and not-for-profit agencies.

3. All housing support funds must be used within 90 days. Any balance remaining after 90 days must be returned to AHRC with a letter indicating the name of the waiver participant and the Region.

4. The agency is responsible for accurately accounting for use of the funds by way of receipts for each item purchased. Copies of the receipts should be maintained in the waiver participants' file along with the Household Goods Actual Expenditures form. (See Appendix A). DOH or its representatives may request an audit of these funds at any time.

The distribution and accounting of Housing Support funds for HCBS/TBI waiver participants is an important function of the service-coordinating agency. It is the responsibility of the agency to maintain accurate accounting of these funds and to return any residual funds by check to AHRC after 90 days. Failure to do so may result in removal of the agency from the list of approved service-coordinating agencies until the situation is resolved, or in some situations, termination of the agency as a HCBS/TBI waiver provider.

Utility Payment Policy

The Department of Health (DOH) may subsidize a portion of a participant's monthly utilities, where applicable. This includes gas, electric, propane, oil and telephone.

DOH will pay the cost of the lowest basic phone service. Call the local telephone provider and request the basic phone service for the waiver participant. After phone service has been established and the first bill arrives, complete a Utility Application, requesting a subsidy for basic phone service and **include a copy of the bill.**

It is recommended that participants establish a monthly budget plan for other utilities also. When a need is demonstrated DOH will pay 2/3 (.67) of the budgeted utility cost and the waiver participant is responsible for paying the balance.

In cases where two waiver participants share living space, first divide the budgeted amount in half, then compute 2/3 (.67) of the that amount. Complete a Utility Application for **each** consumer and include a copy of the bill with each application. The Utility Application should specify whose name the account is under.

In situations where a waiver participant shares living space with a non-waiver participant, the non-waiver individual is responsible for one half of the total bill. DOH will subsidize 2/3 (.67) of the waiver participant's half of the bill. The Utility Application should specify whose name the account is under.

It is the responsibility of the service coordinator to establish a payment plan with the waiver participant and to regularly monitor payments to prevent loss of service due to lack of payment.

Return of Overpayments, Security Deposits, and Housing Support Funds

Overpayments, Security Deposits AND Residual Housing Support Funds must be returned to the DOH Payment Agent (AHRC).

Make checks payable to "**AHRC**."
Indicate the waiver participant's full name and RRDS region.

Forward to:

AHRC –TBI
200 Varick St. 7th Floor
New York, NY 10014
Attention: TBI Housing Program

If you have any questions regarding this policy please contact the RRDS in your region.

Appendix E

New and Revised Policies
April 2003 - March 2004

Policy for Household Goods Expenditures (March 27, 03)
Household Goods Actual Expenditures. (Instructions)
Household Goods Actual Expenditures (form)

Policy for annual Housing Checklists (March 27, 03)
Role of TBI Housing QA Specialist

Policy for four person limit in housing (April 11, 03)

Process to Stop/Decrease Rent or Utility (Aug. 2003)

Letter for Co-Signing Policy (Oct. 14, 03)
Policy regarding Co-Signing for a waiver participant's lease

Letter for revised Waiver Participant Contract (March 9, 2004)
Revised: Waiver Participant Contract for Rental Subsidy

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 27, 2003

Dear Provider:

The DOH TBI Housing Program provides funding for the purchase of household goods for qualified individuals in the Home and Community Based Services for individuals with Traumatic Brain Injury (HCBS/TBI) waiver program. The waiver participant, with assistance from the service coordinator if necessary, is responsible for completing the Housing Support Addendum form listing the items requested and the estimated cost of each item. The Regional Resource Development Specialist (RRDS) approves the allocation of funds and submits the request to Residential Placement Management Systems (RPMs), the TBI Housing Resource for review. The Association for the Help of Retarded Children (AHRC), the TBI Payment Agent, disperses the funds directly to the service coordination agency to be used to purchase the approved items on behalf of the waiver participant.

The service coordination agency is responsible for prudent spending and accurate accounting of Housing Support funds to purchase only those items approved on the Housing Support Addendum. A final accounting of all money spent must be recorded on the Household Goods Actual Expenditures form and retained with the original receipts in the waiver participant's file. The Department of Health or its representative may conduct an audit of these expenditures at any time.

The distribution and accounting of Housing Support funds for HCBS/TBI waiver participants is an important function of the service coordination agency. It is the responsibility of the agency to maintain accurate accounting of these funds and to **return any funds not spent after 90 days of receipt of this letter to AHRC.** Failure to do so may result in removal from the list of approved service coordination agencies until the situation is resolved, or in some situations, termination of the agency as a HCBS/TBI waiver provider.

Return funds with a letter indicating the waiver participant's full name and RRDS region. Make checks payable to " AHRC." Forward to:

AHRC-TBI
4377 Bronx Blvd. 3rd Floor
Bronx, New York 10466
Attention: TBI Housing Program

If you have any questions regarding this policy please contact the RRDS in your region.

Sincerely,

Shirley Gnacik
DOH TBI Housing Program

INSTRUCTIONS
NYS DOH TBI HOUSING PROOGRAM

HOUSEHOLD GOODS ACTUAL EXPENDITURES

1. *Participant:*- Enter participant's last name and first name, No nicknames

2. *Service Coordinator:*- Enter the name of the service coordinator who is responsible for dispersing funds to the participant for approved items.

3. *List of Actual Purchases*:-As items are purchased, a description of the item and the final cost must be entered.

4. *Cost:*- Enter the actual cost of the purchase for approved items. Each item should have a corresponding receipt.

5. *Waiver participant*:-Signature of the participant verifying that purchases have been made on their behalf at the amount indicated for each item.

6. *Date*: The date indicating that all approved purchases have been made

7. *Service Coordinator*:-The signature of the coordinator responsible for distribution and accounting of the housing support funds

8. *Date*:- The date when all approve purchases have been completed and any remaining funds have been returned to AHRC.

NOTE: The service coordination agency and the service coordinator are responsible for ensuring that the Housing Support funds are used for items identified on the Housing Support Addendum and approved by the RRDS. An accurate accounting of the actual costs must be documented on the Household Goods Actual Expenditures form. Original receipts for all purchases must be maintained in the participant's file. DOH or its designee may request an audit of the housing support funds at any time. Any funds not used within 90 days from receipt of the funds must be returned to AHRC, the DOH TBI Payment Agent. (See Policy for Housing Support Funds).

NEW YORK STATE
DEPARTMENT OF HEATLH
TBI HOUSING PROGRAM

HOUSEHOLD GOODS
ACTUAL EXPENDITURES

Waiver Participant _____ RRDS Region _____

Service Coordinator _____ Agency _____

LIST OF ACTUAL PURCHASES	COST
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$
8.	$
9.	$
10.	$
11.	$
12.	$
13.	$
14.	$
15.	$
TOTAL	**$**

I certify that the items listed above have been purchased at the amount indicated.

Waiver Participant Date

I certify that the items listed above have been purchased for the above signed waiver participant at the amount specified. I understand that I am responsible for an accounting of all household funds and must return any unspent money to AHRC after 90 days from receipt of the money.

Service Coordinator Date

Effective April 2003

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 27, 2003

Dear Provider:

The TBI Housing Program is committed to assisting individuals on the Home and Community Based Services for Individuals with Traumatic Brain Injury (HCBS/TBI) Medicaid Waiver find affordable, accessible housing of their choice. Minimum standards for housing were developed to ensure that subsidized housing is comfortable, meets the needs of the waiver participant and remains in good repair. These standards are reflected in the TBI Housing Standards Checklist. The service coordinator is responsible for completing the TBI Housing Standards Checklist before the waiver participant takes residence and then annually in conjunction with the review of the individual service plan.

In order to ensure that all housing subsidized by the TBI Housing Program meets minimum standards and identified deficiencies are addressed, the Department of Health has developed a new position of TBI Housing Quality Assurance Specialist under Residential Management Placement Services (RPMs), the TBI Housing Resource. Renee Bueller will be the Housing QA Specialist at RPMs. She has been involved with the TBI waiver program and is familiar with the housing needs of TBI waiver participants. Attached please find the Role of the Quality Assurance Specialist.

Effective April 1, 2003 all service coordinators should submit a copy of the completed TBI Housing Standards Checklist to the QA Specialist for all new housing receiving rental subsidy through the DOH TBI Housing Program. For current waiver participants receiving rental subsidy, submit the **most recent** copy of the TBI Housing Standards Checklist by April 30, 2003 to the QA Specialist. Annual Checklist reviews should also be forwarded to the QA Housing Specialist.

Send TBI Housing Standards Checklists to:

CUCS
120 Wall Street, 25th floor
New York, NY 10005
Attn: Renee Bueller

If you have any questions concerning this notice, please contact Renee Bueller at 212-801-3312 or Anne Mullaney at 212-801-3334.

Sincerely,

Shirley Gnacik

Shirley Gnacik
Director
TBI Housing Program

Role of TBI Housing Program Quality Assurance (QA) Specialist

The Department of Health developed housing quality assurance standards to ensure that subsidized housing is comfortable, meets the needs of the waiver participant and remains in good repair. These standards are reflected in the TBI Housing Standards Checklist. Service coordinators are required to complete this Checklist and assist with negotiations with landlords if necessary, to bring housing into compliance with TBI housing standards before the waiver participant takes residence. An annual review of housing using the TBI Housing Standards Checklist is required to ensure that housing continues to meet established standards.

The responsibilities of the Housing QA Specialist include:

1. Track completion of all TBI Housing Standards Checklists for housing subsidized by the TBI Housing Program statewide in accordance with TBI Housing Program Guidelines;

2. Review all Checklists to determine that housing meets minimum standards established in the TBI Housing Standards Checklist;

3. Identify possible deficiencies in housing noted on the Checklist;

4. Provide training and technical assistance to service coordinators in completing the Checklist, identifying deficiencies and providing assistance and follow-up to resolve housing problems;

5. Communicate with the RRDSs regarding significant deficiencies in housing in their region, inform them of the plan developed between the QA specialist and the service coordinator to remedy the deficiencies and advise the RDDS of the outcome;

6. Assist with the housing location efforts in New York City; and

7. Visit a sample of housing situations in each region throughout the State to determine compliance with TBI Housing Standards Checklist.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 11, 2003

Dear Providers:

This is to clarify the housing policies and procedures for participants in the Department's Home and Community Based Services Medicaid Waiver for individuals with Traumatic Brain Injury (HCBS/TBI).

As you are aware, the TBI Housing Program, through State appropriated funds, provides rental subsidies and housing supports to TBI waiver participants who are unable to obtain or maintain generic affordable housing without assistance. The current policy, in keeping with federal directives for Home and Community Based Waivers, allows a maximum number of four unrelated individuals to live in a four-bedroom unit dwelling. There have been recent inquiries from provider/landlords as to the possibility of five or more individuals sharing a residence owned and operated by a provider agency. As a result, the TBI program has sought advice about the maximum and minimum number of individuals that might share a provider owned or operated unlicensed residence.

We have worked with the Department's Office of Counsel and Office of Health Systems Management to evaluate the status of a five or more bed residence in light of regulations governing Adult Homes and Family Type Foster Homes. A housing entity that provides, either directly or through arrangement with others, personal care or supervision to five or more residents unrelated to the housing entity (operator) is subject to licensure as an adult home. The provision or arrangement by a housing entity of room, board, laundry, housekeeping, security services, "concierge"-like services, or information and referral services shall not, in and of itself, require that such housing entity be licensed as an ACF. The Department will review each situation on a case-by-case basis to determine whether the proposed arrangement is permissible under law. If the residence were to become an adult home, waiver participants living there could no longer receive TBI Housing Program subsidies. Rather, they may be eligible for either SSI Congregate Care Level II or Safety Net benefits, or would be responsible to privately pay.

The Office of Children and Family and Services (OCFS) has also advised us that a provider/owner occupied residence in which four or fewer individuals who need some care and supervision reside, qualifies as an OCFS Family Type Home for Adults. Family Type Homes for Adults require certification through OCFS. The Department advises all HCBS/TBI waiver providers who operate or contemplate operating an owner occupied residence, with four or fewer individuals who need some care and supervision, to contact OCFS to ascertain whether the setting will in fact require licensure as a Family-Type Home for Adults. Providers may address any questions about certification or potential violations of regulations for Family Type Homes for Adults to Rich Piche of OCFS at (518) 474-9445.

Under the Public Health Law and regulations, a nursing home is a facility engaged primarily in providing nursing care and other health, health-related and social services, by or under the supervision of a physician, for 24 or more consecutive hours to three or more nursing home patients. Providers with questions about whether their housing situation requires this level of certification should contact Ms. Deborah Greenfield, Bureau of Licensure and Certification, NYS DOH, at (518) 478-1101. She can assist in answering questions about either adult home or nursing home regulations.

While the HCBS/TBI waiver program currently has a few waiver participants living in adult homes, this is not the preferred housing situation for waiver participants. The Office of Medicaid Management, in keeping with federal directives for Home and Community Based Services (HCBS) Medicaid Waivers, continues to support TBI waiver housing policy regarding choice of generic affordable housing in the least restrictive setting for waiver participants. It is our expectation that Regional Resource Development Specialists (RRDSs) and service coordinators will continue to adhere to these policies, ensuring that waiver participants are able to consider all appropriate housing options.

Please keep the TBI Program apprised of any housing situations that may be at issue or any inquiries that are made about certification of TBI residences. And, if you have any questions regarding the contents of this notice, please contact Ms. Shirley Gnacik, of my staff, at (518) 474-6580.

Sincerely,

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management

cc: Robert Dougherty
Betty Rice
Susan Somers
Deborah Greenfield

Policy regarding process to STOP/DECREASE Rent or Utility Payments August 2003

Recently there have been an increased number of requests to retain ("hold") monthly rent or utility checks prior to RPMs receiving the appropriate Status Change form to STOP or DECREASE the payment. This action is no longer acceptable.

The only way a monthly check may be STOPPED is by faxing or mailing the Status Change form to RPMs before the 15th of the month. E-mails and phone calls are not acceptable forms of notification.

Service coordinators should be reminded that paperwork to STOP or DECREASE a monthly payment should be submitted as soon as they are aware of the situation. When the RRDS is aware that a STOP/DECREASE RENT or UTILITY is necessary to prevent a monthly check from being mailed AND the Service Coordinator is not available to submit the necessary Status Change form, the RRDS should sign and submit the form to RPMs as soon as possible. The service coordinator can submit an additional Status Change form with new information if necessary. This saves the RRDS from the lengthy process of trying to recoup the overpayment and allows for the money to be directly added to the RRDS regional housing budget.

If you have any questions, please feel free to contact Shirley Gnacik (518) 474-5427.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

October 14, 2003

Dear Provider:

This letter is in response to a request from some providers for clarification of a provider agency's responsibility regarding co-signing for an apartment for a TBI consumer.

The necessity for co-signing is mainly limited to the New York City regions. However, there may be situations when consumers have not established a credit record or have a poor credit history prior to coming onto the waiver and a landlord requires a co-signature.

The attached policy clarifies the role of the service coordination agency and the Department of Health.

NOTE: This policy should be added to the May 2003 Housing Guidelines as page 6a. This is not a replacement page but an ADDITION to the Housing Guidelines manual.

If you have any questions regarding this policy, please contact me at (518) 474-6580.

Sincerely,

Shirley Gnacik
Director TBI Housing Program

Role of the Service Coordinator and Service Coordination Agency

Co-signing for a waiver participant's lease

The TBI Program encourages landlords to accept the signature of the waiver participant on a lease. If a co-signature is required, a family member should be encouraged to assume this responsibility. When this is not possible, the service coordination agency may be asked to function as the co-signer for the waiver participant. In these situations, the landlord usually dispenses with a co-signature at the time of lease renewal if the waiver participant has successfully met the terms of the lease.

The service coordination agency is not under contractual agreement with DOH to act as a co-signor for a waiver participant. However, the inability to assist a waiver participant in procuring housing which needs a co-signer may limit the individuals that the agency is able to serve. The RRDS should be informed of the agency's willingness to co-sign if it became necessary.

If the service coordination agency agrees to co-sign on behalf of the waiver participant, and the participant defaults on the terms of the lease, or moves before the term of the lease, the DOH Housing Location Agency (RPMs) and the Department of Health, if necessary, are available to the waiver participant and the agency to negotiate with the landlord to resolve the issue. The *co-signing agency will not be held responsible for any remaining rental costs.*

It is important for the service coordination agency to assist the waiver participant to meet the terms of his lease agreement and to work closely with the DOH Housing Locator, RPMs, to diminish the chances of potential problems between a waiver participant and a landlord.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller-Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 9, 2004

Dear Service Coordination Provider:

The TBI Waiver Housing Program has revised the Consumer Agreement contained in the Housing Guidelines released in May 2003. Providers should discontinue use of the current "Consumer Agreement" and begin using the attached "Waiver Participant Contract" by **April 1, 2004**. A copy of the Contract should also be placed in your agency's copy of the May 2003 Housing Guidelines.

Please not the following revisions:

- The title of this form has been changed from Consumer Agreement to Waiver Participant Contract for Rental Subsidy.

- The language of the Contract has been simplified to make it clearer and the statements are changed from "You" to "I." This is to emphasize to the waiver participant their personal obligation to adhere to these conditions in order to remain eligible to receive a DOH Housing Program rental subsidy.

- Three new conditions have been added to the contract. The numbers coincide with the numbers on the new Contract.

  #3 outlines the requirement of the TBI Housing Program to apply for Section 8 HUD housing, maintain an active application and to accept HUD housing if it becomes available. The waiver participant may need the assistance of the Service Coordinator to complete paperwork to maintain an active Section 8 application with the local HUD office. It is important to notify the HUD office when there is a change of address and provide any other information that the HUD office may require to maintain the individual on an active eligibility list.

#8 clarifies the consequences of having someone else move into an apartment, which is subsidized by DOH.

#13 indicates that no structural changes may be made to the apartment without the written consent of the landlord and contact with the Service Coordinator.

- One item from the Consumer Agreement has been clarified.

#4 informs the waiver participant that if the monthly income increases, the amount the individual is required to contribute towards rent will also increase.

If you have any questions regarding this notice, or need a copy of the May 2003 Housing Guidelines, please contact me at (518) 474-6580.

Shirley Gnacik

Director TBI Housing Program

NEW YORK STATE DEPARTEMENT OF HEALTH
WAIVER PARTICIPANT CONTRACT
FOR RENTAL SUBSIDY

Rev. 3/04

Individuals in the TBI Waiver Program who are receiving a rental subsidy from the Department of Health must agree to all of the following conditions. Failure to comply may result in loss of your rental subsidy.

In order to be eligible for the TBI Housing Program and continue to receive a rental subsidy I understand that:

1. I must be a participant in the TBI Waiver Program.
2. I must be receiving Medicaid and I must make sure that any "spend down" requirements to maintain my Medicaid are met each month.
3. I must apply for a Section 8 HUD rental subsidy and maintain the application process. If HUD housing becomes available, I am required to accept it and discontinue the TBI Housing Program rental subsidy.
4. I am responsible to pay one third (1/3) of my total monthly income towards my rent. If my monthly income increases, I understand that the amount I pay towards rent each month will also increase.
5. I understand that it is very important that the rent be paid each month in a timely fashion.
6. I may NOT withhold my portion of the rent for any reason. Any problems with the landlord or apartment should be discussed the landlord or building superintendent. If the problem is not resolved, I should speak with my Service Coordinator.
7. I understand that any person over 18 years old who lives in my apartment is required to pay their portion of the rent, utilities and other expenses of the apartment. For example: If two people live in the apartment, each is required to pay half of the expenses. If three people live in the apartment each is required to pay 1/3 of all expenses. This includes family members and children over 18 years old.
8. I understand that if someone moves into my apartment, the DOH rental subsidy I receive will be reduced accordingly. If the other individual does not pay their portion of the expenses I risk the possibility of eviction from my apartment. DOH is not responsible for another person's portion of the rent due to non-payment of rent.
9. I will not engage in unlawful activities in my apartment or common areas. This includes, but is not limited to, the possession, and/or sale of illegal drugs, disturbances or acts of violence that damage or destroy the dwelling unit or disturb or injure other residents.

Appendix F

New and Revised Policies
April 2004 - March 2005

Lease Limit of One Year (Sept. 2004)

Food Stamp Eligibility (Sept. 2004)

Process for when a Waiver Participant Relocates (Sept. 2004)

Cover letter for Payback and Number of Rooms Policy (Jan 05)

Policy regarding Payback Policy (Jan 2005)

Policy for Determining Number of Bedrooms (legal custody) and Subsidy Amount for a Participant Living with non-Waiver Participants (Jan 2005)

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

September 7, 2004

Dear Service Coordination Provider:

In May 2003 the TBI Housing Guidelines for the Home and Community Based Services Waiver for individuals with Traumatic Brain Injury (HCBS/TBI) was distributed to Service Coordination agencies. Since that time there have been clarifications, revisions and additions to the Housing Program policies.

In March 2004 Service Coordination agencies received a copy of "Appendix E- New and Revised Policy – April 2003- March 2004. This Appendix contains information regarding:

1. Requirement for submittal of Housing Standard Checklists for DOH subsidized housing
2. Description of the Role of the Quality Assurance Specialist
3. Distribution and accounting for Housing Support Funds
4. Limitations of 4 unrelated individuals per dwelling
5. Policy Regarding process to Stop/Decrease Rent or Utility Payments
6. Co-signing by Service coordination providers
7. Revised Waiver Participant Contract.

Enclose please find documents to initiate Housing Guidelines "Appendix F- New and Revised Policy April 2004-March 2005." This includes:

1. Cover sheet for Appendix F
2. Lease Limit of One Year
3. Food Stamp Eligibility
4. When a Waiver Participant Relocates

Please add these documents to your May 2003 copy of the TBI Housing Guidelines.

If you have any questions regarding this notice or need a copy of the TBI Housing Guidelines please contact me at (518) 474-5427.

Sincerely,

Shirley Gnacik
TBI Housing Program

New York State Department of Health
TBI Housing Program

September 2004

Lease Limit of One Year for DOH Subsidized Housing

A waiver participant who is applying to receive, or is currently receiving a rental subsidy from the TBI Housing Program should sign a lease of no more than one year.

Waiver Participants may become hospitalized, incarcerated, choose to move from an apartment or, in rare instances, be terminated from the TBI Waiver. Limiting a lease to no more than one year allows the waiver participant and the Housing Program the flexibility to deal with these situations.

Early termination of a lease is costly to the program in both time negotiating with the landlord and potential payment for remaining months of rent. The Housing Locator agency is available to assist the service coordinating agency, if necessary, with negotiations with the landlord and should be informed as soon as possible when early termination of a lease is anticipated.

If a lease agreement for more than one year is signed, and the lease is prematurely terminated, the Housing Program will not be responsible for any payments to the landlord beyond the first twelve months of the lease.

Any additional payments beyond the 1 year period which are due to an increase in rent above fair market rent or resulting from early termination of the lease will be the responsibility of the waiver participant.

It is important for the Service Coordinating agency to obtain a copy of all new and renewal leases for waiver participant's receiving a TBI rental subsidy.

New York State Department of Health
TBI Housing Program

September 2004

Food Stamp Eligibility for Individuals in TBI Waiver Housing Program

All individuals in the Department of Health TBI Waiver should be encouraged to apply for food stamps to supplement their income.

When applying for Food Stamps, if the waiver participant is receiving a rental subsidy from the TBI Housing Program, this subsidy should NOT be considered as income by the Department of Social Services as the subsidy is sent directly to the landlord.

The waiver participant is required to contribute 1/3 of his/her monthly income towards rent. This should be considered an expense for the individual.

If the Department of Social Services has any questions regarding the TBI rental subsidy, they should be referred to the RRDS for clarification of the DOH TBI Waiver and the Housing Program.

New York State Department of Health
TBI Housing Program

September 2004

When a Waiver Participant Relocates

When a participant wants to relocate it is important to determine if there is a current lease and when the lease expires before beginning an apartment search. Early termination of leases is costly in both time in negotiating with the landlord and money to pay for penalties for early termination. When possible, try to time relocations to coordinate with termination of a lease. Landlords should be given a written notice at least 30 days prior to move out date.

If assistance negotiating with the landlord is needed, the Service Coordination agency may contact the DOH Housing Locator, Center for Community Urban Services, Anne Mullaney at 212-801-3334.

Check List for moving out of an apartment

_____ Make sure that the waiver participant paid their last month's contribution to the landlord.

_____ Call all utilities to cancel service, including cable service

_____ Submit a STOP Utility form including all subsidized utilities and the correct account number.

_____ Remove all waiver participant items from the apartment.

_____ Don't leave any trash or other items in the apartment Dispose of all trash in the proper receptacle(s).

_____ Return all keys to the landlord on the day of move out.

_____ If one participant moves out of a shared, 2-bedroom apartment submit a STOP rent form for the moving participant and a Change Rent Status form for the participant staying in the apartment.

_____ Transfer the security deposit to the remaining participant.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

January 2005

Dear Service Coordination Provider:

Periodically the TBI Housing Program is required to provide clarifications and updates to policies contained in the TBI Housing Guidelines distributed in March 2003.

Attached please find:

1. **Payment Request for Back Payment**
   This policy outlines the forms and procedure to be followed when DOH is required to pay the participant's portion of back rent.

2. **Guidelines for Determining Number of Bedrooms...**
   This policy provides guidelines for determining the number of bedrooms allowable by DOH for a rental subsidy when a participant lives with other individuals who are not TBI waiver participants and when a participant has legal custody of a child.

Please add these clarifications to TBI Housing Guidelines in Appendix F: New and Revised Policy, April 2004 – March 2005. If you need a copy of the TBI Housing Guidelines, please contact me at (518) 474-6580.

<u>These policies are effective upon receipt of this notice</u>. If you have any questions regarding the content of this notice, please contact your Regional Resource Development Specialist (RRDS).

Sincerely,

Shirley Gnacik

Shirley Gnacik
Director, TBI Housing Program

Payment Request for Back Payment of Participant's Portion of Rental Subsidy

Failure of participants to pay their portion of the rent while receiving a DOH rental subsidy is in violation of the Consumer Agreement (see Appendix E of Housing Guidelines for revised Agreement). Repeated defaulting of payment may result in eviction and/or termination from the rental subsidy program.

When nonpayment occurs the Service Coordinator is required to assist the participant to work with the landlord to determine an acceptable payback arrangement. Closer supervision is needed to ensure that no further defaults occur and the payback occurs as scheduled.

If DOH is required to pay the participant's portion of the unpaid back rent, the participant is responsible for reimbursing DOH for the amount of that payment. The DOH subsidy will be decreased and the participant portion paid to the landlord will increase to meet the total rent due.

Therefore, Payment Requests submitted to cover a participant's portion of back rent and/or late fees must include:

1. A Narrative, including explanation of the reason for failure to pay, plan for repayment, and plan of correction to prevent a reoccurrence.

2. A Rent Status Change form indicating a reduction in the DOH subsidy ($10- $20 per month), the subsequent increase in the participant's portion, and the date when the payback to DOH will be complete. (When payback is complete, a new Rental Status Change is necessary to return to the appropriate DOH subsidy).

New York State Department of Health
Bureau of Long-Term Care
January 2005

Guidelines for Determining Number of Bedrooms and DOH Subsidy Amount for a Participant Living with non-Waiver Participants

When applying for a DOH rental subsidy for a participant who is living with others who are not participants in the TBI waiver (including but not limited to spouse, parent, grandparent, sibling, children, friend, in-law, etc.) it is necessary to determine:

1. the number of bedrooms DOH will subsidize
2. the fair market rate for multiple bedrooms
3. the number of individuals responsible for contributing towards the cost of rent and utilities

1. Number of bedrooms

- The number of bedrooms allowable for a DOH subsidy is based on the number of family members living together 100% of the time.

- A participant must currently have legal custody of a minor child for more than 50% of the time in order for the child to be considered in determining the necessary number of bedrooms for the family.

2. Fair Market Rate

- The RRDS has a listing of Fair Market Rates (FMR) for 1 to 4 bedrooms for each county

3. Individuals living with a waiver participant who are required to contribute towards the costs of rent/ utilities

- Any individual over age 18 who is not a TBI waiver participant regardless of income, employment status or entitlement status
- Any child over 18 years old who is not a full time student. The RRDS and/or Service Coordinator may request proof of enrollment status.

Note: Any entitlements received for or by minor children residing with the participant will be included in the participant's "income after spend-down" amount.

For specific guidelines in determining a DOH subsidy based on the number and ages of family members see Housing Guidelines, "When a waiver participant and spouse..."

New York State Department of Health
Bureau of Long Term Care
January 2005

Appendix G

New and Revised Policies
April 2005 - March 2006

Cover letter for When a Waiver Participant is Living with an Individual Who Owns the Home (June 2005)

Policy related to When a Waiver Participant is Living with an Individual Who Owns the Home (June 2005)

Policy and Revised form related to Waiver Participant Contract for Rental Subsidy (November 2005)

Cover letter regarding documents to be included in Appendix G (May 2006)

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

Dear Service Coordination Provider:

Enclosed, please find documents to be included in the Traumatic Brain Injury (TBI) Housing Guidelines dated May 2003. The following documents should be added to "Appendix G-New and Revised Policies, April 2005 – March 2006":

1. Cover sheet for Appendix G;
2. Cover letter for When a Waiver Participant is Living with an Individual Who Owns the Home, (June 2005);
3. Policy related to When a Waiver Participant is Living with an Individual Who Owns the Home, (June 2005); and
4. Policy and Revised form related to Waiver Participant Contract for Rental Subsidy, (November 2005).

Also enclosed is a new policy for the TBI Waiver's Housing Program. Please notify all Service Coordinators of this change. This information will initiate "Appendix H –New and Revised Policies, April 2006 – March 2007" of the TBI Housing Guidelines:

1. Policy Requiring Certificate of Occupancy for All Subsidized Housing

   Since April 2003, the Department of Health (DOH) has required that Service Coordinators complete a Housing Standards Checklist on all housing subsidized by the TBI Housing Program. It is beyond the scope of a Service Coordinator to ensure that any living situation meets all required State and local building codes and standards. If a residence meets all applicable codes and standards, a Certificate of Occupancy (C of O) is issued to the owner of the property by the local Building Department. In order to ensure that housing subsidized by the TBI Housing Program meets all building standards, evidence of a current C of O is now required in most instances. Evidence of a C of O must be received by the Quality Assurance Specialist by December 31, 2006 for all living situations currently receiving a rental subsidy from the TBI Housing Program.

Service Coordination agencies are responsible for training their providers regarding the implementation of these policies and forms.

If you have any questions regarding this notice please contact Shirley Gnacik of my staff at 518-474-6580.

Sincerely,

Betty Rice, Director
Division of Consumer and Local District Relations

When a Waiver Participant is Living with an Individual Who Owns the Home

Effective June 2005

Occasionally, a waiver participant may choose to live with someone (parents, family members or non-related individuals) who owns a home which they share with the participant. In this situation, the participant has his/her own bedroom but the kitchen and other living spaces are shared with the owner of the home. There is no "rent" in this situation since the other individual(s) own(s) the property. **DOH does not pay waiver housing subsidies to banks for mortgage payments.**

If the waiver participant is required to pay a monthly amount to the owner and it is determined that there is a financial need for DOH assistance, the calculation of the DOH subsidy must be calculated as follows:

For one participant living with the home owner, the total monthly payment may not exceed one half of the fair market rate for a one bedroom apartment in the county where the participant resides.

When the participant living with the home owner also has a spouse or child the total monthly payment may not exceed one half of fair market rent for the appropriate number of bedrooms as defined in the Guidelines for Determining Number of Bedrooms (see Appendix F).

As with any DOH rental subsidy, the participant is required to contribute one third of his/her total monthly income toward this payment. A spouse and/or adult child must also contribute to the monthly payment using the same guidelines as a rental subsidy for an apartment.

The total number of bedrooms in the home or the owner's mortgage amount have no impact on the housing subsidy calculation.

Policy related to Waiver Participant Contract for Rental Subsidy

The Waiver Participant Contract for Rental Subsidy was revised in November 2005 to better define the rights and responsibilities of a waiver participant requesting a rent or utility subsidy from the TBI Housing Program.

It is the responsibility of the Service Coordinator to explain to the participant the requirements of the Contract, including the consequences of violating the conditions of the Contract.

The waiver participant is required to review and sign a new contract in the following situations:

- With an initial rent subsidy application;
- Annually with the Housing Standards Checklist, and
- With each application for an increase in rent subsidy.

Each time the Contract is signed, the original must be forwarded to the RRDS, a copy maintained in the waiver participant's file and a copy provided to the waiver participant. When the Contract is signed in conjunction with completion of the annual Housing Standards Checklist, a copy must also be forwarded to the Quality Assurance Specialist.

Violation of the conditions of the Contract may result in the waiver participant being discontinued from the TBI Housing Program.

NEW YORK STATE DEPARTMENT OF HEALTH
WAIVER PARTICIPANT CONTRACT
FOR RENTAL SUBSIDY

Rev. 11/05

This contract must be reviewed with the waiver participant and signed when: (a) initially applying for a housing subsidy; (b) annually at the time of lease renewal; and (c) anytime there is a change in address or amount of rental subsidy.

Individuals in the Traumatic Brain Injury (TBI) waiver who are receiving a rental subsidy from the TBI Housing Program must agree to all of the conditions below. **Failure to comply with the terms of this contract may result in a decrease in the TBI rental subsidy and/or termination from the TBI Housing Program.**

In order to be eligible for the TBI Housing Program and to continue to receive a rental subsidy I understand that:

1. I must be a participant in the TBI waiver.
2. I must participate in my services as described in my Service Plan.
3. I must be receiving Medicaid and I must make sure that any "spend down" requirements to maintain my Medicaid are met each month.
4. I must apply for a Section 8 HUD rental subsidy and maintain an active application. If HUD housing becomes available, I am required to accept it and discontinue the TBI Housing Program rental subsidy.
5. I must provide my Service Coordinator with all information regarding my finances including but not limited to my total monthly income, savings, supplemental needs trust, and awards from SSI and/or SSDI. I must inform my Service Coordinator immediately of any changes to my finances.
6. I must pay one third (1/3) of my total monthly income (after spend down) towards my rent. If my monthly income increases, I understand that the amount I pay towards rent each month will also increase. Income received from SSI, DSS, SSDI and/or child support for minor children living with me is included in my monthly income.
7. I must pay my portion of the rent on time each month. Failure to pay on time may result in a reduction in my rent subsidy or termination from the TBI Housing Program.

Waiver Participant _____

Advocate/Guardian _____

Service Coordinator _____

NEW YORK STATE DEPARTMENT OF HEALTH
WAIVER PARTICIPANT CONTRACT
FOR RENTAL SUBSIDY

Rev. 11/05

8. I may NOT withhold my portion of the rent for any reason. Any problems with the landlord or apartment should be discussed with my Service Coordinator.

9. If anyone moves into my apartment who is not a waiver participant, they are responsible for one half of all rental and utility expenses and my TBI rental subsidy will be reduced accordingly. If the other individual does not pay their portion of the expenses I risk the loss of my TBI rental subsidy and termination from the TBI Housing Program.

10. I must abide by all agreements of the lease.

11. I must not engage in unlawful activities in my apartment or common areas. This includes, but is not limited to, the possession and/or sale of illegal drugs and disturbances or acts of violence that damage or destroy the dwelling unit or disturb or injure other residents.

12. I must not permit my guests to engage in unlawful activities in the apartment or the common areas.

13. I must not cause disruption in the building or be disrespectful to my fellow tenants.

14. I must pay for all repairs to the apartment or appliances, which are due to damages that I caused.

15. When I move out, I must remove all personal property and trash from the premises and return the keys to the landlord.

16. If DOH has paid for my security deposit and if some or all of the deposit is not refunded due to my actions or neglect, I understand that my future rental subsidy may be decreased or terminated until the expense has been recouped.

17. I must not make any changes to the structure of the apartment without obtaining written permission from my landlord and consulting with my Service Coordinator.

18. If I share the apartment with another TBI waiver participant, the furnishings purchased by the TBI Housing Program for common living areas belong to both tenants equally. If one participant moves out, an agreement must be reached on how to distribute the furnishings.

19. Each TBI wavier participant shall have the right of complete privacy in his or her own bedroom.

Waiver Participant _____

Advocate/Guardian _____

Service Coordinator _____

NEW YORK STATE DEPARTMENT OF HEALTH
WAIVER PARTICIPANT CONTRACT
FOR RENTAL SUBSIDY

Rev. 11/05

20. I am responsible for maintaining any furniture purchased for my residence with money from the Department of Health. Damaged and ruined furniture will not be replaced.

21. I must report any needed repairs in my apartment to my Service Coordinator.

22. I must not leave anything in or on the fire escapes, sidewalks, entrances, exits, driveways, elevators, stairways, or halls.

23. If for any reason the TBI Housing Program pays any part of my portion of the rent, my rental subsidy will be decreased and the amount I owe the landlord will be increased each month until all money has been refunded to the TBI Housing Program.

24. I must inform my Service Coordinator BEFORE I sign a lease renewal. I understand that the TBI Housing Program will only be responsible for one year leases.

25. In order for my rental subsidy to continue, I must permit a visit from my Service Coordinator and/or the Housing Locator agency at least annually to complete a Housing Standards Checklist.

I have read the TBI Housing Contract. I understand and agree to all the terms and conditions as stated. I understand that violations of any of these conditions may result in a decrease in my rental subsidy or termination from the TBI Housing Program. I accept the terms of this contract and the Housing Support and Rental Subsidy Application.

Waiver Participant _____ Date _____

Advocate/Guardian _____ Date _____

Service Coordinator _____ Date _____

Appendix H

New and Revised Policies
April 2006 - March 2007

Cover letter for Policy Requiring Certificates of Occupancy for all Subsidized Housing

Policy Requiring Certificates of Occupancy for all Subsidized Housing (June 2006)

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner
Commissioner

Dennis P. Whalen
Executive Deputy

June 2005

Dear Service Coordination Provider,

Attached please find a clarification of the Housing Guidelines for the Home and Community Based Services waiver for Individuals with Traumatic Brain (HCBS/TBI).

This policy relates only to waiver participants who shares common living space with an individual who owns the dwelling they share. This policy defines the procedure for determining a Department of Health (DOH) monthly rental subsidy in this situation. This policy affects new applications for a DOH rental subsidy effective June 1, 2005.

This policy is the first policy of the 2005-2006 state fiscal year. Each year a new appendix is added to contain any policy changes for that year. Please include this policy in a new "Appendix G- New and Revised Policy for 2005-2006" in your agency's copy of the TBI Housing Guidelines dated May 2003.

If you have any questions regarding this policy, please feel free to contact me at (518) 474-6580.

Sincerely,

Shirley Gnacik
Director, TBI Housing Program

Policy Requiring Certificates of Occupancy for all Subsidized Housing

Since April 2003, the Department of Health (DOH) has required that the Service Coordinator complete a Housing Standards Checklist, at least annually, during an on-site visit for all living situations subsidized by the Traumatic Brain Injury (TBI) Housing Program. The completed Checklist documents any deficiencies or safety hazards in the dwelling which may be a potential risk to the waiver participant.

It is beyond the scope of the Service Coordinator and the Housing Standards Checklist to ensure that an apartment, apartment building, house or other dwelling meets all building codes and standards for safety and occupancy which may be required by a local municipality. This is determined through inspection by the local Building Department. If the dwelling meets all applicable codes and standards, a Certificate of Occupancy (C of O) will be issued to the owner of the property by the local Building Department.

In order to better protect the waiver participants and ensure that property subsidized by the TBI Housing Program meets local building standards, the Department will now require all property receiving a rental subsidy from the TBI Housing Program to have documentation of a current C of O.

An acceptable C of O identifies the address of the property, the number of residential units certified and the approved use for the building. The dates of issue and termination of certification are noted on the C of O. The certification may be approved for several years but a new C of O must be issued by the local Building Department when there is:

- An initial occupation of a new building;
- An alteration of an existing building;
- A change in the use of a building;
- A Building Permit issued; and
- A documented C of O that has expired.

Documentation of C of O may be obtained from the landlord, at the office of the local Building Department or, when available, from a local Building Department's website. It is the responsibility of the landlord to produce this documentation.

Service Coordinators are required to document the issue number of the current C of O in the waiver participant's file and on the annual Housing Standards Checklist for all living situations receiving a rental subsidy from the TBI Housing Program.

For housing currently subsidized by the TBI Housing Program, the C of O issue number must be submitted to the Regional Resource Development Specialist (RRDS) and the Quality Assurance Specialist no later than December 31, 2006.

Initial applications and requests to increase a current subsidy for rent or utilities must include a C of O issue number on the Narrative and the Housing Standards Checklist beginning July 1, 2006. Service Coordinators should verify a current C of O for a housing situation prior to showing housing to the participant or signing a lease.

All annual Housing Standards Checklists must include documentation that a C of O has been reviewed and the number of the certificate. In situations where a C of O number cannot be obtained, the Service Coordinator must document this in the participant's file and notify the RRDS and the Quality Assurance Specialist. For municipalities that do not issue C of Os, a notation must be included in the participant's file and on the annual Housing Standards Checklist.

The TBI Housing Program will not subsidize any housing situations that do not have a current and appropriate C of O, or documentation indicating why a C of O cannot be obtained. If a C of O or appropriate documentation cannot be obtained, the waiver participant must be relocated to another setting which meets DOH Housing Program standards.