

# HCBS Autism Policy and Procedure Manual Outline

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## **A-1 Description and Use of the Manual**

The Home and Community Based Services (HCBS) Autism Waiver Manual contains the official policies and procedures to be used when providing services under the HCBS Waiver for children with an Autism Spectrum Disorder (ASD). ASD includes Autism, Asperger Syndrome and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). The information in this manual was developed through a policy and procedure review process conducted by Community Supports and Services (CSS), a unit of the Kansas Department of Social and Rehabilitation Services/Division of Disability and Behavioral Health Services. It is consistent with the Medicaid Waiver criteria set forth by the federal Centers for Medicare and Medicaid Services (CMS). Providers are encouraged to become familiar with the contents of the manual and refer to it as the first course of action when questions arise.

It is the responsibility of the provider to also review the Provider Manual in the Kansas Medical Assistance Program (KMAP). It can be viewed at: <https://www.kmap-state-ks.us/>

## **A-2 Maintenance of the Manual**

The Manual will be revised and updated as policies change. The holder of the Manual is responsible for adding updates to the Manual as they become available. Updates can only be made by CSS. When revisions are made to the manual, instructions for filing the revised material will be distributed to all service providers.

## **A-3 History of Autism in Kansas**

Title XIX (Medicaid) of the federal Social Security Act is a public assistance medical care program administered by states and financed jointly through federal and state funds. The purpose of the program is to help states meet the costs of necessary health care for low-income and medically needy populations. In 1981, Congress authorized the waiver of certain Title XIX requirements to enable states to provide home and community based services to Individuals who would otherwise require institutional care. The waiver programs are called 1915 (c) waivers after the section of the Social Security Act that authorized them.

Due to the drastic increase in diagnosed cases of Autism Spectrum Disorders, the Kansas Department of Social and Rehabilitation Services (SRS) Disability and Behavioral Health Services (DBHS) and Community Supports & Services submitted an HCBS Autism Waiver application to Centers of Medicaid and Medicare Services (CMS) on July 5, 2007. Prior to SRS/CSS submitting an HCBS Autism Waiver, SRS/DBHS/CSS with the support of the Governor's Commission on Autism sought the input of many stakeholders in the development of this waiver. To begin the process of creating an early intensive intervention Autism Medicaid Waiver Program, SRS in conjunction with the Governor's

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Commission on Autism held three public forums across the state to meet with parents and families to determine what services were needed. Following the forums, eleven (11) stakeholder meetings were held which included parents, early childhood experts, advocates, and providers. Groups were formed and met regularly from October 2006 to June 2007 to formulate recommendations for what the Waiver Program should entail. Prior to submission of the HCBS Autism Waiver, three additional public forums were held across the state to meet with parents and families.

At the time of the HCBS/Autism Waiver renewal of the waiver, (Jan 1, 2011) SRS/DBHS/CSS along with the support of stakeholders sought CMS's approval to add one additional service to the HCBS Autism waiver. As a result of CMS's approval SRS/DBHS/CSS was able to add Interpersonal Communication Therapy to the HCBS Autism Waiver.

The HCBS Autism waiver is an early intensive intervention waiver for children who upon entrance to the waiver a must be between the age of 0 through 5 years of age, who have a diagnosis of an Autism Spectrum Disorder or Pervasive Developmental Disorder-Not Otherwise Specified. Children are required to meet functionally eligibility guidelines and Kansas' financially eligible guidelines for Medicaid, utilize two waiver services every month and without waiver services would be at risk of being placed in an Inpatient psychiatric facility for individuals under 21 years of age as provided in 42CFR440.160. HCBS Autism Waiver services are limited to 3 years unless medically necessary. For reason of medical necessity services may be extended for one year, one time with approval of the review team. The autism review team will consist of the HCBS Autism Program Manager, a therapist or an individual who works with children with autism and an Autism Specialist who is not directly involved with the child/family requesting the extension. For the purpose of this waiver, only the child's income is considered (not parental income) when determining Medicaid financial eligibility.

### **A-4 How the original 25 children were selected for the Autism Waiver**

SRS/DBHS/CSS assumed these positions would fill quickly. In order to be fair to every family statewide the following steps were established for parents who wish to have their child considered for the HCBS Autism Waiver. With the exception of the random selection for the first 25 positions on the waiver this is a first come first served waiver. There is no Crisis funding, or exceptions granted for obtaining a position on the HCBS Autism Waiver. However, a child from another waiver could transfer to the Autism Waiver, providing the child meets the guidelines set forth.

Steps for Parents;

1. The family must complete an Autism preliminary application form. The application is one page long and was/is available at their local SRS Regional Service Center, Community Developmental Disability Organizations (CDDO's), Community Mental Health Centers (CMHC's), Community Service Providers, Foster Care Contractors, Families Together, Keys for Networking, other stakeholders, or they could go to Community Supports & Services' web-site,

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<http://www.srs.ks.gov/agency/css/Pages/Autismwaiver/AutismWaiver.aspx> to download the application.

2. Fully completed applications are to be faxed to CSS, at 785-296-0557 (number is on the application) or taken to a local SRS office where they were time/date stamped and faxed to CSS, or mailed to Docking State Office Building, 915 SW Harrison, 9<sup>th</sup> Floor, Attention: Community Supports & Services.
3. All applications postmarked on or before January 11, 2008 were made available for the random selection of numerical assignment for the first 25 positions.
4. On January 17, 2008, CSS identified the random numerical assignment impartially assigned to each application.
5. Children with numbers 1 through 25 were offered a position on the Autism Waiver.
6. The Autism Program Manager provided the names of the 25 children to the contracted Functional Eligibility Specialist(s) (FES).

Children numbered 26 and above received a letter from the Autism Program Manager informing them they that have been placed on the “Proposed Waiver Recipient List”. When a position on the Waiver becomes available and the child’s name is at the top of the list, the Program Manager will contact the family to offer them the position. All applications received after January 11, 2008 will be add to the list on a first come first served.

**A-5 HCBS Autism Program Administration and Operation**

The Kansas HCBS Autism Waiver Program is administered by Community Supports and Services, which is a department of Social and Rehabilitation Services/Division of Disability and Behavioral Health Services. CSS is responsible for formulating HCBS Autism policies and procedures within the framework of state and federal laws and regulations. CSS is also responsible for overseeing the Waiver Program to ensure that it is effectively and efficiently implemented throughout the state.

Functional Eligibility Specialist is a contracted service for the HCBS Autism Waiver. The FES will utilize the Vineland II Survey Interview Adaptive Behavior Scale to assess the level of functional impairment for children seeking entry to the waiver program. Financial eligibility is determined by Economic Employment Support (EES) Specialist in local SRS offices. Because a portion of eligibility determination is completed by different agencies, communication among these agencies is crucial.

Once a child has been determined functionally eligible for the HCBS services, the family must complete the choice form and chooses an Autism Specialist. A referral will then be made to the Autism Specialist. The Autism Specialist is responsible for the assessment

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of the child and family's strengths and needs utilizing a criterion reference skill based assessment, development of the Individualized Behavioral Program/Plan of Care, coordinate services, training and technical assistance to the family and paid support staff and monitoring of the child's progress within the program. Each child receiving HCBS Autism Waiver services has a Plan of Care that identifies, at a minimum: 1) medical and other services (regardless of funding sources) to be furnished; 2) the frequency, amount and duration of waiver services; and 3) the provider who will furnish each service. The Plan of Care (Waiver services only) must be entered into the Medicaid Management Information System (MMIS) so that claims for authorized services will be reimbursed to the providers who delivered the authorized service.

The Autism Program Manager approves Plans of Care. In addition, SRS Regional Field Staff, (Quality Assurance (QA) and Performance Improvement (PI)) conduct annual reviews of each HCBS Autism Waiver child. Cases are reviewed for accuracy in assessment, appropriateness of the Plan of Care, technical accuracy of forms completion and case file documentation as well as claims payment review.

### **A-6 SRS/DBHS/CSS Goals**

- Children Thrive
- Families & children Achieve Maximum Self-Sufficiency
- Families & children live in safe, stable and supportive environments
- Families & children are satisfied with services

### **A-7 HIPAA Compliance**

As a Kansas Medical Assistance Program website participant, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with Section 45 of the Code of Regulations, parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto. A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of the provider's employees. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

### **A-8 Laws and Case Law**

Listed below are important federal and state laws and recent case law that has

affected people with disabilities.

1953 – Kansas Act Against Discrimination

This state law addresses the illegal discrimination of people with disabilities and other protected classes in the areas of employment, housing and public accommodations. Amended several times over the years, it is currently considered to be substantially equivalent to several federal laws including the Fair Housing Act, Title VII of the Civil Rights Act and the Americans with Disabilities Act.

1964 - Civil Rights Act

Signed into law by President Lyndon Johnson, the Civil Rights Act (amended 1991) prohibits discrimination in employment and public accommodations on the basis of race, color, national origin, religion, sex, age or disability.

1970 - Urban Mass Transit Act

This act requires all new mass transit vehicles be equipped with wheelchair lifts.

1973 – Rehabilitation Act

A landmark law, the Rehabilitation Act bars discrimination against persons with disabilities by programs receiving Federal funds, particularly Title V, Sections 501, 503, and 504.

1975 - Developmental Disabilities Bill of Rights Act

This act establishes, among other things, Protection and Advocacy Services (P&A).

1975 – IDEA- Education of all Handicapped Children (PL 94-142)

This law requires free, appropriate public education in the least restrictive environment for children with disabilities. This law was amended in 1997 and is now called the Individuals with Disabilities Education Act (IDEA).

1988 - Civil Rights Restoration Act

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Congress overrode President Reagan's veto and reversed the impact of unfavorable case law (the 1984 United States Supreme Court [USSC] ruling in *Grove City College vs. Bell*) by clarifying Congress' original intention under the Rehabilitation Act. The Act restores the reach of Title IX and other laws that prohibit discrimination by entire programs that receive federal funding (not just the part of the program which directly receives the funding).

1988 – Fair Housing Amendments Act

Originally passed in 1968, this act was amended and now prohibits discrimination in housing and related transactions based on race, color, national origin, sex, religion, disability and familial status. It also provides for architectural accessibility of certain new housing units, renovation of existing units and accessibility modifications at the renters expense. The Act covers all kinds of housing related transactions, including rentals, home sales, mortgage lending, homeowners' insurance, home improvement and zoning.

1990 – Americans with Disabilities Act (ADA)

A landmark comprehensive civil rights law, the ADA bans job discrimination on the basis of disability and requires businesses, public transportation and other public facilities to be made accessible to persons with disabilities.

1991- Civil Rights Act (as amended)

This act legislatively reversed the USSC's 1989 decision that narrowly interpreted job discrimination laws and provides money damages for victims of intentional job discrimination to compensate them for their injuries and to deter future employer wrong doing.

1998 – *Bragdon vs. Abbott*

This was the first ADA case to make its way to the USSC which holds, among other things, that HIV+ individuals are protected under the ADA.

1999- *Olmstead vs. L.C.*

This case reaffirms that Title II of ADA bars the unnecessary segregation of people with disabilities in state institutions. As the USSC noted, such segregation is often motivated by irrational fears, stereotypes and patronizing attitudes and unfairly regulates individuals with disabilities to second-class status.

## **B-1 Definitions**

The following words and terms in the HCBS Autism Waiver and other commonly used phrases have the following meaning, unless the context clearly indicates otherwise.

**3160** Notification of Medicaid/HCBS Services Referral/Initial Eligibility/Assessment/ Services Information - The State of Kansas form utilized to notify the Social Rehabilitation Services Economic and Employment Support worker to initiate services for HCBS.

**3161** Notification of Medicaid/HCBS/Working Healthy Services – The State of Kansas form utilized to inform the SRS EES worker of changes in HCBS service costs, contacts and/or closure of HCBS Autism Waiver services.

**ABA (Applied Behavior Analysis)** - ABA is a systematic process of studying and modifying observable behavior by changing the environment. ABA includes the use of direct observation, measurement (data collection) and functional analysis of the relations between environment and behavior. ABA uses antecedent stimuli and consequences based on the findings of descriptive and functional analysis to produce practical change. According to Autism Speaks, behavior analysis is a natural science of behavior that was originally described by B.F. Skinner in the 1930's. Since the early 1960's, hundreds of behavior analysts have used positive reinforcement and other principles to build communication, play, social, academic, self-care, work and community living skills and to reduce problem behaviors in learners with autism of all ages. Some ABA techniques involve instruction that is directed by adults in highly structured fashion, while others make use of the learner's natural interests and follow his or her initiations. Still others teach skills in the context of ongoing activities. All skills are broken down into small steps or components, and learners are provided many opportunities to learn and practice skills in a variety of settings, with abundant positive reinforcement. The goals of intervention, as well as the specific types of instructions and reinforces used, are customized to the strengths and needs of the individual learner. Performance is measured continuously by direct observation, and intervention is modified if the data show that the learner is not making satisfactory progress. Regardless of the age of the learner with autism, the goal of ABA intervention is to enable him or her to function as independently and successfully as possible in a variety of environments. The National Institute of Child Health and Human Development lists Applied Behavior Analysis among the recommended treatment methods for Autism Spectrum Disorders (Autism Speaks, 2007). According to the American Academy of Pediatrics Clinical Report, single-subject and controlled studies have documented the effectiveness of ABA-based intervention for children with Autism Spectrum Disorder (Myers & Johnson, 2007).

**ASD (Autism Spectrum Disorder)** - ASDs include Autism, Asperger Syndrome and Pervasive Developmental Disorder – Not Otherwise Specified. ASDs are a group of

developmental disabilities defined by significant impairments in social interaction, communication and the presence of unusual behaviors and interests.

**Abuse** - Any act or failure to act that results in any of the following to a child under the age of 18 who resides in Kansas or is found in Kansas, regardless of where the act or failure to act occurred: Death, physical injury or deterioration or the imminent risk of serious injury, mental or emotional injury or deterioration or sexual abuse (K.S.A. 38-2201).

**Adverse** - Actively opposed, failing to promote one's interests or welfare, in an opposite or opposing direction or position.

**Assessment** - Face-to-face interview and evaluation of a child who receives home and community-based services by an authorized assessor to determine the care needs of the child and support systems and to develop a service plan.

**Assistive Services** - Services which meet an individual's assessed need and/or result in an increase in the person's level of independence by modifying or improving an individual's home and through provision of adaptive equipment (e.g., ramps, lifts) and is a cost-effective alternative to personal services.

**Augmentative and Alternative Communication (AAC)** - Use of forms of communication other than speaking, such as: sign language, "yes/no" signals, gestures, picture board and computerized speech systems.

**Autism Specialist (AS)** - Consultative Clinical and Therapeutic Services (CCTS) is an HCBS Autism waiver service provided by an Autism Specialist. Those services include: assessment of the child and family's strengths and needs, development of the individual behavioral program and Plan of Care, coordination of services, training and technical assistance to the family and paid support staff in order to carry out the program and monitoring of the child's progress within the program.

**Behavior** - Any observable skill, action or reaction of a child (social skills, adaptive or challenging behaviors). This may be appropriate or inappropriate.

**Case File Management** - The section in the manual that explains the "Why of Documentation" for Autism Specialist, when to send Notice of Action, the transferring the case to another agency and service discharge.

**Choice** - An act of choosing; power, right or liberty to choose; a number or variety from which to choose; something best or preferable; an alternative.

**Criterion Referenced Skill Based Assessment (CRSBA)** - A type of assessment that measures behaviors and behavior change based on a defined level of performance. The initial assessment will establish baseline levels across the skill domains. Follow-up assessments will determine progress across the same domains.

**DBHS (Disability and Behavioral Health Services)** a division under SRS who administer and manages HCBS Waivers.

**DTT (Discrete Trial Training)** – A specific method of teaching used to maximize learning. It is a method within the science of Applied Behavior Analysis that involves providing numerous discrete opportunities to practice a skill. The discrete trial sequence involves a stimulus or instruction, a behavior and the consequence for that behavior (such as reinforcement). It is a teaching technique or process used to develop many skills, including cognitive, communication, play, social and self help skills.

**Early Intensive Behavioral Intervention (EIBI)** – A method based on the science of Applied Behavior Analysis that systematically teaches small, measurable units of behavior.

**Economic and Employment Support (EES) Specialist** - SRS staff member located in SRS regional offices who determines financial eligibility for Medicaid.

**Effective Date** - The date a program or service begins which is the first date a provider can be reimbursed for services. The HCBS effective date establishes the date an individual is considered an HCBS recipient. A person is an HCBS recipient if he or she has been assessed, found in need of long term care services, chooses to receive HCBS services and those services are available, and services have been scheduled to begin, (KEEMS 8200.2)

**Eligibility** - Refers to the process whereby an individual is determined to be eligible for health care coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data is collected and managed by the State or by its fiscal agent.

**Empowerment** - The process of helping individuals, families, groups and communities increase their personal, interpersonal, socioeconomic and political strength and influence with the goal of improving their circumstances.

**Exploitation** - Misappropriation of an adult’s property or intentionally taking unfair advantage of an adult’s physical or financial resources. K.S.A. 39-1430

**Fair Hearing** - The opportunity to be heard or to present ones side of a case, free from prejudice or favoritism.

**Family** – For the purpose of this waiver “family” is defined as persons who live with or provide care to a child served on the Waiver and may include a parent, stepparent, legal guardian, siblings, relatives, grandparents or foster parents.

**Family Adjustment Counseling (FAC)** – FAC is an HCBS Autism waiver service. FAC is counseling for the family members of a child with an ASD to guide and help them cope with the child’s illness and the related stress that accompanies the initial understanding of

the diagnosis and the ongoing continuous, daily care required to support the child with an autism spectrum disorder.

**Formal Service** - Any needed service as documented in the Plan of Care and funded by Medicaid.

**Functional Behavioral Assessment (FBA)** - A process through which an attempt is made to uncover conditions that could be cuing or maintaining behavior.

**Functional Eligibility Assessment** - The process by which a child's level of care (functional eligibility) will be determined. This process utilizes the Vineland II, a standardized assessment of adaptive behaviors across multiple domains (receptive/expressive language, home/community functioning, social interaction, motor skills and problematic behaviors).

**Functional Eligibility Specialist (FES)** - The contracted individual who will conduct the Functional Eligibility Assessment.

**Health Care Financing Administration (HCFA)** - Former name of the government agency now called the Centers for Medicare & Medicaid Services (CMS).

**Health and Human Services, Department of (HHS)** - Administers many of the social programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" of CMS.)

**Health Insurance Portability & Accountability Act (HIPAA)** - A law passed in 1996, which is also sometimes called the "Kassebaum-Kennedy" law. This law expands your health care coverage if you have lost your job or if you move from one job to another. HIPAA protects you and your family if you have: pre-existing medical conditions, and/or problems getting health coverage and you think it is based on past or present health. HIPAA also:

- provides confidentiality guidelines;
- limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage;
- usually gives you credit for health coverage you have had in the past;
- may give you special help with group health coverage when you lose coverage or have a new dependent; and, generally, guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.

**Individualized Behavioral Program (IBP)** - An assessment summary the Autism Specialist completes with the child/family input. The Plan of Care is developed from the IBP and justifies the HCBS services the child will be utilizing.

**Informal Services** - Any needed or desired service provided voluntarily to a consumer by any organization, agency, friend or family member at no cost to the Medicaid program. This is also referred to as natural supports.

**Intensive Individual Supports (IIS)** - An HCBS Autism waiver service. The IIS person works under the direction of the Autism Specialist to assist the child in acquiring, retaining, improving and generalizing skills including self-help, socialization and adaptive skills necessary to reside and function successfully in home and community settings.

**Interpersonal Communication Therapy** – (ICT) services works toward remediation of social communication symptoms relate to the diagnosis of an autism spectrum disorder and will be provided through evidence based methodologies.

**KAECSES** - The computer program/system used to determine eligibility and benefit levels for SRS cash programs, vision cards (for food) and medical assistance. In addition, KAECSES compiles data for various reports, computes overpayments and under payments and provides detailed case information, current and historic, either on-line or in reports

**Kan-Be-Healthy (KBH)** - A program that offers Medicaid services to anyone under the age of 21 who has a State medical card. Regular Medicaid services are covered plus participants can receive additional services. This program may also be referred to as Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Medicaid's comprehensive and preventive child health program for individuals under the age of 21.

**Level of Care** – Identifies the functional needs of children, as determined through an assessment or reassessment of the child's impairments. The Vineland II Survey Interview Adaptive Behavior Scales is the instrument used to make this determination.

**Mandated Reporter-** Kansas law requires persons in specific professions to report suspected abuse, neglect, exploitation or fiduciary abuse of adults residing in the community. Failure to report is a class B misdemeanor. (See K.S.A. 38-2223)

**Medicaid-** A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medicaid Management Information System (MMIS)** - A CMS-approved system that supports the operation of the Medicaid program.

**Medically Necessary-** Services or supplies that: 1) are proper and needed for the diagnosis or treatment of a medical condition; 2) are provided for the diagnosis, direct care and treatment of a medical condition; 3) meet the standards of good medical practice in the local area; and 4) are not mainly for the convenience of the person or their doctor.

**Medicare Part A (Hospital Insurance)** - Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

**Medicare Part B (Medical Insurance)** - Medical insurance that helps pay for doctors' services, outpatient hospital care and other medical services that are not covered by Part A.

**Mental Retardation** - Significantly sub-average general intellectual functioning that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. The onset must occur before age 18 years.

**Mental or emotional abuse** - The infliction of mental or emotional injury on a child or the causation of a child's deterioration (K.A.R 30-46-10)

**Neglect** - Any act or omission resulting in harm to a child or presenting a likelihood of harm if the act or omission is not due solely to the lack of financial means of a child's parent or other custodian. This term shall include any act or omission involving a child under the age of 18 who resides in Kansas or is found in Kansas, regardless of where the act or failure to act occurred. This term shall also include any act or failure to act that occurred in Kansas, regardless of where the child is found or resides. (K.A.R 30-46-10 & K.S.A. 38-2202).

**Notice of Action (NOA)** – The State of Kansas form utilized to notify consumers when there is a change in services, providers and Medicaid eligibility status. In the event of an adverse (negative) action being taken, the Functional Eligibility Specialist or Autism Specialist will send a Notice of Action to the consumer notifying them of any changes to their services. An adverse Notice of Action is to be sent to the consumer giving them 10 calendar days, plus one day for mailing, plus one day to receive mail prior to the action date the change occurs.

**Parent Support and Training (PST) (peer to peer)** - An HCBS Autism waiver service designed to provide the training and support necessary to ensure engagement and active participation of the family in the treatment process. Ongoing implementation and reinforcement of skills will be learned throughout the treatment process.

**Person Centered Plan/Planning (PCP)** – The PCP is both a process and a written document. The process includes the PCP meeting which focuses on identifying an individual's needs, strengths and interests and the subsequent development of the written document. The written document incorporates the strengths and needs of the individual into an individualized plan with goals, objectives and a plan (services) to accomplish those goals.

**Physical Abuse** - The infliction of physical injury on a child or the causation of a child's deterioration. This term shall include any non accidental or intentional action or inaction that results in bodily injury or that presents the imminent risk of serious injury.

**Plan of Care (POC)** - A document which delineates what paid services will be provided, the service provider, frequency and cost. Natural supports are also identified that will assist the child and family. The Plan of Care must be renewed at least annually.

**Positive Behavior Support (PBS)** – The utilization of research-based strategies to intervene when an individual presents with challenging behaviors. Based in the science of human behavior, these strategies focus on redesigning environments and provide supports to make the challenging behavior(s) ineffective, inefficient and unnecessary.

**Prior Authorization (PA)** - Any service that is to be provided in accordance with the POC, will be reimbursed only when approval is given before the service is provided. This is accomplished through the use of the MMIS system.

**Quality Assurance (QA)** - The process of determining if the program parameters and goals are being followed.

**Reassessment** - A face-to-face annual review and evaluation of a child's continued need and/or eligibility for HCBS Autism waiver services.

**Recoupment**- The recovery by Medicaid of any Medicaid debt by reducing present or future payments and applying the amount withheld to the indebtedness.

**Reimbursement** - The dollar value assigned by the Secretary of SRS for a covered service.

**Relationship Development Intervention (RDI)** - According to Autism Speaks, RDI is based on the work of psychologist Steven Gutstein. RDI focuses on improving the long term quality of life for all individuals on the spectrum. The RDI program is a parent-based treatment that focuses on the core problems of gaining friendships, feeling empathy, expressing love and being able to share experiences with others. Dr. Gutstein's program is said to be based on extensive research in typical development which then translates research findings into a systematic clinical approach. His research found that individuals on the autism spectrum seemed to lack certain abilities necessary for success in managing the real life environments that are dynamic and constantly changing. Dr Gutstein , who along with Dr. Rachelle Sheely , formed the Connections Center For Family and Personal Development based in Houston Texas in 1995, says, "We are challenging families and professionals to think beyond achieving mere functionality as a successful outcome for individuals with autism; our reference point for success in the RDI program is quality of life." The goal is social improvements as well as changes in flexible thinking, pragmatic communication, creative information processing and self-development. The program offers training workshops for parents as well as several books that offer step-by step exercises building motivation so that skills will be utilized and generalized. The program is said to be able to be started easily and implemented into regular, daily activities that enrich family life. (Autism Speaks, 2007). According to the American Academy of Pediatrics Clinical Report, sufficient evidence of RDI treatment

efficacy, in the form of empirical scientific research, is currently lacking (Myers & Johnson, 2007).

**Residence** – A person’s residence is wherever he or she makes his or her home. This may be their natural home, Foster Care Placement or a relative’s home but does not include hospitals, skilled nursing facilities or State Mental Health hospital.

**Respite Care** – An HCBS Autism waiver service that provides temporary direct care and supervision for the child. The primary purpose is relief to families/caregivers of a child with an ASD. Normal activities of daily living are considered content of the service when providing respite care and include support in the home, after school or at night.

**Scientific Evidence** – means controlled clinical trials that either directly or indirectly demonstrate the effectiveness of the intervention on health outcomes

**Secondary Payer** - Insurance policy, plan or program that pays second on a claim for medical care. This could be Medicare, Medicaid or other health insurance depending on the situation. Medicaid is always the payer of last resort.

**Sexual Abuse** - Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child or another person. Sexual abuse shall include allowing, permitting or encouraging a child to engage in prostitution or to be photographed, filmed or depicted in pornographic material (K.S.A. 38-2202).

**Treatment and Education of Autistic and related Communication –handicapped children (TEACCH)** – According to Autism Speaks, TEACCH is a special education program that is based on general guidelines and is tailored to the autistic child's individual needs. It dates back to the 1960's when doctors Eric Schopler, R.J. Reichler and Ms Margaret Lansing were working with children with autism and constructed a means to gain control of the teaching setup so that independence could be fostered in the children. What makes the TEACCH approach unique is that the focus is on the design of the physical, social and communicating environment. The environment is structured to accommodate the difficulties a child with autism has while training them to perform in acceptable and appropriate ways. Some children with autism are visual learners. TEACCH brings visual clarity to the learning process in order to build receptiveness, understanding, organization and independence. The children work in a highly structured environment which may include physical organization of furniture, clearly delineated activity areas, picture-based schedules and work systems, and instructional clarity. The child is guided through a clear sequence of activities and thus aided to become more organized. It is believed that structure for autistic children provides a strong base and framework for learning. Though TEACCH does not specifically focus on social and communication skills as fully as other therapies it can be used along with such therapies to make them more effective. (Autism Speaks, 2007). According to the American Academy of Pediatrics Clinical Report, while the TEACCH method reports progress in children as well as improvements in parent teaching skills and satisfaction, most of the

reports are not the product of controlled studies of treatment outcomes (Myers & Johnson, 2007).

**Termination Date** - The last day on which a program or service will be reimbursed. This date should not extend beyond the last day of Medicaid eligibility.

**Timely Filing** - The receipt by the agency or its fiscal agent of a claim for payment from a provider for services provided to a Medicaid program consumer. The claim for payment should be submitted no later than 12 months after the date of the claimed services.

**Utilization Review**- Contractor (EDS) reviews of Medicaid claims to ensure that the service was necessary and appropriate.

## B-2 Acronyms

Abbreviation	Definition
<b>A</b>	
AAC	Augmentative and Alternative Communication
ABA	Applied Behavior Analysis
ADA	Americans with Disabilities Act
ADOS	Autism Diagnostic Observation Scale
ADI	Autism Diagnostic Interview – Revised
APS	Adult Protective Services
AS	Autism Specialist
ASD	Autism Spectrum Disorders
ASDS	Asperger Syndrome Diagnostic Scale
AT	Assistive Technology
<b>B</b>	
BCBA	Behavior Analyst Certification Board
<b>C</b>	
CARS	Childhood Autism Rating Scale
CCTS	Consultative Clinical and Therapeutic Services (Autism Specialist)
CDDO	Community Developmental Disability Organization
CMHC	Community Mental Health Center
CMS	Center for Medicaid/Medicare Services
CPS	Child Protective Services
CRSBA	Criterion Reference Skill Based Assessment
CSP	Community Service Provider
CSS	Community Supports and Services
<b>D</b>	

DOS	Dates of Service
DTT	Discrete Trial Training
Dx	Diagnosis
DBHS	Disability and Behavioral Health Services
<b>E</b>	
ECS	Electronic Claim Submission
EDS	Electronic Data Systems
EES	Economic and Employment Support Specialist
EIBI	Early Intensive Behavioral Intervention
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
<b>F</b>	
FAC	Family Adjustment Counseling
FBA	Functional Behavioral Assessment
FES	Functional Eligibility Specialist
<b>G</b>	
<b>H</b>	
H&E	Dept. of Health and Environment (KDHE)
HCBS	Home Community Based Services
HCBS Autism	HCBS Autism
HCBS MR/DD	HCBS Mental Retardation and Developmental Disabilities
HCBS SED	HCBS Severe Emotional Disturbance/Severely Emotionally Disturbed
HCBS TA	HCBS Technology Assisted
HHS	Health and Human Services
HIPAA	Health Insurance Portability & Accountability Act of 1996
<b>I</b>	
IBP	Individualized Behavioral Program/Plan, Individual Behavioral Program
ICT	Interpersonal Communication Therapy
IDEA	Individuals with Disabilities Education Act
IDF	Information Disclosure Form
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
IIS	Intensive Individual Supports
IL	Independent Living
<b>K</b>	

KAECSES	Kansas Automated Eligibility Child Support Enforcement System
KAMP	Kansas Accessibility Modification Program
KAPS	Kansas Advocacy and Protective Services
KAR	Kansas Administrative Regulations
KBH	KAN Be Healthy
KBI	Kansas Bureau of Investigation
KDHE	Kansas Department of Health and Environment
KEESM	Kansas Economic and Employment Support Manual
KHPA	Kansas Health Policy Authority
KMAPP	Kansas Medical Assistance Program
KSA	Kansas Statutes Annotated (Laws)
<b>L</b>	
LMN	Letter of Medical Necessity
LOC	Level of Care
<b>M</b>	
MMIS	Medical Management Information System
MR	Mental Retardation
<b>N</b>	
N/A	Not applicable
NOA	Notice of Action
<b>O</b>	
OAH	Office of Administrative Hearings
OT	Occupational Therapy/Therapist
<b>P</b>	
PA	Prior Authorization
PBS	Positive Behavior Supports
PCP	Person Centered Planning
PDD	Pervasive Developmental Disorders
PDD-NOS	Pervasive Developmental Disorder Not Otherwise Specified
PI	Performance Improvement
PM	Program Manager
POC	Plan of Care
PPF	Parent Participation Fee
PST	Parent Support and Training
PT	Physical Therapy/Therapist
<b>Q</b>	

QA	Quality Assurance
QE	Quality Enhancement
<b>R</b>	
RC	Respite Care
RDI	Relationship Development Intervention
<b>S</b>	
SED	Severe Emotional Disturbance/Severely Emotionally Disturbed (waiver)
SLP	Speech Language Pathologist
SMHH	State Mental Health Hospital
SRS	Social and Rehabilitation Services
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSN	Social Security Number
SUR	Surveillance and Utilization Review
SW	Social Worker
<b>T</b>	
TA	Technical Assistance
TCM	Targeted Case Manager/Management
TEACCH	Treatment and Education of Autistic and Communication-Handicapped Children)
Tx	Treatment
Title XIX	...of the Social Security Act: Federal Funds source for medical and nursing home payments
Title XX	...of the Social Security Act: Federal funds source for social service payments
Title XXI	Health Wave
<b>U</b>	
UR	Utilization Review

**B-3 Kansas Regulations and Statutes**

a. Kansas Administrative Regulations (K.A.R.s)

The following are K.A.R.'s that apply to the HCBS Services:

**30-5-301** Provider participation.(A) Each provider shall meet the provider participation requirement specified in K.A.R. 30-5-59, including record keeping requirements, and the following additional requirements: (1) All assessment records; (2) All plan of care records, and (3) All case file documentation records.

- 30-5-304** Cost efficient plans of care. (a) Each HCBS plan of care shall be cost efficient and shall be provided in accordance with K.A.R. 3-5-70.
- 30-5-305** Assessment requirements. (a) Qualified staff and assessment providers shall conduct an assessment prior to the implementation of any HCBS service.
- 30-5-307** Family reimbursement restriction. (a) An adult consumer's spouse cannot be paid to provide HCBS services to that consumer. A minor consumer's parents cannot be paid to provide HCBS services to that consumer (b) Unless one of the four criteria noted below are met.
1. Consumer's residence is documented in writing by three HCBS provider agencies to be so remote or rural that HCBS services would be otherwise unavailable.
  2. Consumer's health, safety, or social welfare would be jeopardized and is so documented in writing by two health care professionals including the attending physician.
  3. Due to advancement of chronic disease, consumer's primary means of communication can only be understood by the spouse or parent of minor child and is so documented in writing by the attending physician.
  4. Written documentation from three HCBS providers that delivery of HCBS services to the consumer poses serious health or safety risks for providers thereby rendering HCBS services otherwise unavailable.
- 30-5-308** Non-supplementation of HCBS services. (a) An organization, agency, or family shall not be allowed to pay for additional services of the same type as those described on the plan of care.

b. Kansas Statutes Annotated (K.S.A.s)

Kansas Statutes Annotated that effect the HCBS Autism Waiver:

- 38-2201** This section is the Kansas Code for Care of Children and refers to the reporting of certain abuse or neglect of children.
- 39-1430** This section refers to reporting the abuse, neglect or exploitation of persons which the law defines as "Mentally Ill, Incapacitated and Dependent Persons."
- 39-1431** This section refers to the reporting of abuse, neglect or exploitation, delineates those individuals who are required to report such incidents and states the penalty for failure to do so.

### **C-1 Program Eligibility**

To be eligible to receive Home Community Based Services (HCBS) Autism Waiver services a child must meet all of the following requirements:

- a. Be a Kansas resident
- b. Be eligible for the Kan-Be- Healthy (KBH) Program
- c. Be Medicaid eligible (only the child's income is considered for this waiver)
- d. Upon entrance to the waiver, a child must be between the age of birth through their fifth year of age
- e. Receive a diagnosis of Autism, Asperger's or Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS) from a licensed Medical Doctor or Ph.D. Psychologist using a recommended Autism Specific screening tool. The approved diagnostic tools are:
  - CARS - Childhood Autism Rating Scale
  - GARS - Gilliam Autism Rating Scale
  - ADOS - Autism Diagnostic Observation Scale
  - ADI - Autism Diagnostic Interview- Revised
  - ASDS - Asperger Syndrome Diagnostic Scale
  - Other : Autism specific tools as approved by SRS  
*(If other, contact the Autism Program Manager)*
- f. Meet the functional (level of care) eligibility guidelines established utilizing the Vineland II Survey Interview Adaptive Behavior Scale
- g. Be in need of utilizing two waiver services on a monthly basis.

### **C-2 Social Rehabilitation Services (SRS) Goals**

- a. Children Thrive
- b. Families and Children Achieve Maximum Self-Sufficiency
- c. Families and Children live in safe, stable and supportive environment
- d. Families and Children are satisfied with services

### **C-3 Responsibilities of the Parent**

- a. Participate in the development of the Individualized Behavioral Program/Plan of Care (IBP/POC).
- b. Participate and interact with trained staff in assisting their child to acquire, retain, improve and generalize the self-help, socialization and adaptive skills necessary for the child to reside and function successfully in home and community settings.
- c. Inform providers of any change in the status, good or bad, and when their child goes into the hospital.
- d. Develop a backup plan for the care of the child when a provider fails to show up at their scheduled time.
- e. Inform providers ahead of time when provider services are not needed.

*Eligibility*

- f. In the event a parent would like to change their current Autism Specialist (AS), the parent will notify the Autism Program Manager either by phone or letter of their desire to change Autism Specialist's.

**C-4 Services Not Covered by HCBS Autism Waiver**

- a. Services when the child is in the hospital or other institution.
- b. Services for the convenience of the child, family or caregiver, such as the services of a sitter.
- c. Autism Waiver services do not duplicate other Medicaid State Plan Services or other services otherwise available to the child at no cost.
- d. Services at any time the child does not qualify for Medicaid or does not meet the eligibility guidelines.

**C-5 Functional Criteria (Level of Care) - Initial Vineland II Assessment and Reassessment**

All applicants for HCBS Autism Waiver services who receive a diagnosis of Autism Spectrum Disorder (ASD) and upon entrance to the waiver are between the ages of 0 through 5 years of age must undergo an assessment to determine functional (Level of Care) determination. The Functional Eligibility Specialist (FES) will verify diagnosis prior to completing the functional eligibility determination when:

- The family submitted their application and indicated on the application that an Autism Spectrum Disorder diagnosis was made with the Diagnostic & Statistical Manual of Mental Disorders (DSM) and does not indicate or provide documentation as to which approved autism screening tool was used in conjunction with the DSM diagnosis.
- The application is signed by a Licensed Medical Doctor or Ph.D. Psychologist and there is no indication which approved Autism screening tool was used.

When the Autism Program Manager makes the referral to the FES she/he will indicate at that time if the diagnosis needs to be verified. To verify the diagnosis, the FES will review documentation indicating which autism-specific screening tool was used. If a family has "other" documentation in which a diagnosis of an Autism Spectrum Disorder was determined then the Functional Eligibility Specialist will contact the Autism Program Manager.

When additional documentation is required from the family to verify diagnosis the family has ten (10) calendar days from the time they are contacted by the FES to present the requested documentation. The only exception is when a Doctor state in writing that thirty (30) days is necessary to complete the necessary forms.

## *Eligibility*

SRS utilizes the Vineland II Survey Interview Adaptive Behavior Scale because of its ability to measure the personal and social skills of individuals from birth through adulthood. Since adaptive behavior refers to an individual's typical performance of the day-to-day activities required for personal and social sufficiency, these scales assess what a person actually does, rather than what he or she is able to do. The Vineland II assesses adaptive behavior in four domains: Communication, Daily Living Skills, Socialization and Motor Skills. The following explains how each item is rated:

- 2 (behavior is usually or habitually performed)
- 1 (sometimes or partly performed)
- 0 (never performed).

In addition, there is a code "N" for instances when the child has never had the opportunity to perform the activity and a code "DK" when the caregiver does not know if the child performed the activity. It also provides a composite score that summarizes the individual's performance across all four domains.

A qualified contracted Functional Eligibility Specialist conducts an assessment of a child who is applying for waiver services utilizing the Vineland II. The child must have a total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living skills, Socialization and Motor skills) of two standard deviations below the mean of 100 (i.e., a score of 70 or below) in order to be eligible for the Waiver.

OR

A total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living Skills, Socialization and Motor skills) of one standard deviation below the mean of 100 (score of 71-85). This prompts the assessor to review the scores on the Maladaptive Behaviors (internal, external or total). If the Maladaptive Score on the internal, external or total is clinically significant, a v-scale score of 21-24, the child is eligible for the Waiver.

*Note: The Vineland II assessment does not score children below three years of age in the maladaptive area.*

Once it has been determined the child meets the functional eligibility guidelines, the FES will:

- Explain what HCBS Autism Waiver services are.
- Have the family complete and sign the CHOICE FORM, (AW-001) accepting HCBS Autism Waiver services. Choice Form is completed at the time of assessment and reassessment.
- Assist the family in completing the Medicaid application (if the child does not currently have Medicaid).

## *Eligibility*

*Note: If a child is enrolled in Healthwave they must still complete a Medicaid application.*

- Provide parents with information and the Information Disclosure Form (IDF) from the Parent Participant Fee program.
- Provide the family with a list of qualified Autism Specialists so the family can choose an Autism Specialist Provider.
- Obtain release(s) of information (AW-002) from the family.
- Refer child/family to the Autism Specialist of their choice.
- Send a 3160 form to the local SRS Economic and Employment Support (EES) Specialist and copy the Autism Specialist, (if known) notifying them that the child has been determined eligible for HCBS Autism Waiver program. Section III of the 3160 form, under “comments” is where the FES indicates who the family has chosen for an Autism Specialist (providing an Autism Specialist has accepted the case). The FES will provide the Autism Specialist’s contact information so the EES worker can notify the Autism Specialist when Medicaid approval has been granted.

*Note: For the Autism Waiver the effective date of the waiver is the Assessment date.*

- Send a Notice of Action (NOAAW-007) to the child/family informing them the child does not meet the Functional eligibility guidelines for the HCBS Autism Waiver.
- At the time an annual re-determination is completed, send a 3161 form to the EES worker and a NOA to the child/family, Autism Specialist and Program Manager, informing each party of the results of the annual re-determination.

If the child does not meet the Functional Eligibility guidelines, the FES will:

- Send a Notice of Action to the child/family informing them the child does not meet the eligibility guidelines and copy the Program Manager.
- If appropriate, provide information on other available resources in the geographic area.
- Not evaluate a child more than one time a year for the purpose of determining waiver eligibility unless Disability and Behavioral Health Services (DBHS) or the Autism Program Manager gives prior approval for another evaluation.

A functional eligibility determination is completed annually for each child receiving HCBS Autism Waiver services so Community Supports & Services (CSS) can guarantee the Centers for Medicare & Medicaid Services (CMS) that the child continues to be eligible for waiver services. HCBS Autism Waiver services are limited to 3 years unless it is medically necessary to continue services. If the review team finds it is medically necessary for the child to continue receiving waiver services, there is a one time, one year extension only.

The FES will maintain a copy of the Vineland II assessment/re-assessment and Choice Forms in their files and send the originals to the Autism Specialist the family has chosen. All functional determinations (initial or reassessments) are face-to-face in the child/family's environment.

The FES completes a reassessment the month prior to the child's eligibility due date.

**Example:** Johnny's initial functional eligibility determination was completed on July 6, 2007; therefore his annual determination would have to be completed in the month of June 2008. By having the re-assessment completed the month prior to the due date we can eliminate any interruptions of service due to paperwork not being process in a timely matter.

## **C- 6 How to Apply for HCBS Autism Waiver Services**

Since this is a first come first served waiver there is no crisis funding or exceptions granted for obtaining a position on the HCBS Autism Waiver. However, a child from another waiver could transfer to the Autism Waiver, providing the child meets the guidelines set forth.

Steps for Parents;

1. The family will complete an Autism preliminary application form. The application is one page long and will be available at their local SRS Regional Service Center, Community Developmental Disability Organizations (CDDOs), Community Mental Health Centers (CMHCs), Community Service Providers, Foster Care Contractors, Families Together, Keys for Networking, other stakeholders or they can go to Community Supports & Services' web-site, <http://www.srskansas.org/hcp/cssindex.htm>, to download the application.
2. Fully completed applications must be a) faxed to CSS, at 785-296-0557 (number is on the application) or b) taken to a local SRS office to be time/date stamped and faxed to CSS or c) mailed to Docking State Office Building, 915 SW Harrison, 9<sup>th</sup> Floor, Attention: Community Supports & Services.
3. The Functional Eligibility Specialist has five (5) working days to contact the family in order to set up a home visit and complete the functional eligibility determination to decide if the child meets the established criteria.
4. If the child meets the criteria, the Functional Eligibility Specialist will assist the family in completing the Medicaid application (if necessary) and provide the family with a list of available Autism Specialists. *Before a family chooses an Autism Specialist they will need to contact him/her to ensure he/she is still accepting families and/or he/she ascribes to same form of therapy the family wishes to utilize.* If the family has already been working with an enrolled Medicaid Provider for Autism Services, a referral will still need to be sent to the Autism Specialist.

*Eligibility*

5. The Autism Specialist has five (5) working days to contact the family to set up a time for the development of the Individualized Behavioral Plan/Plan of Care.

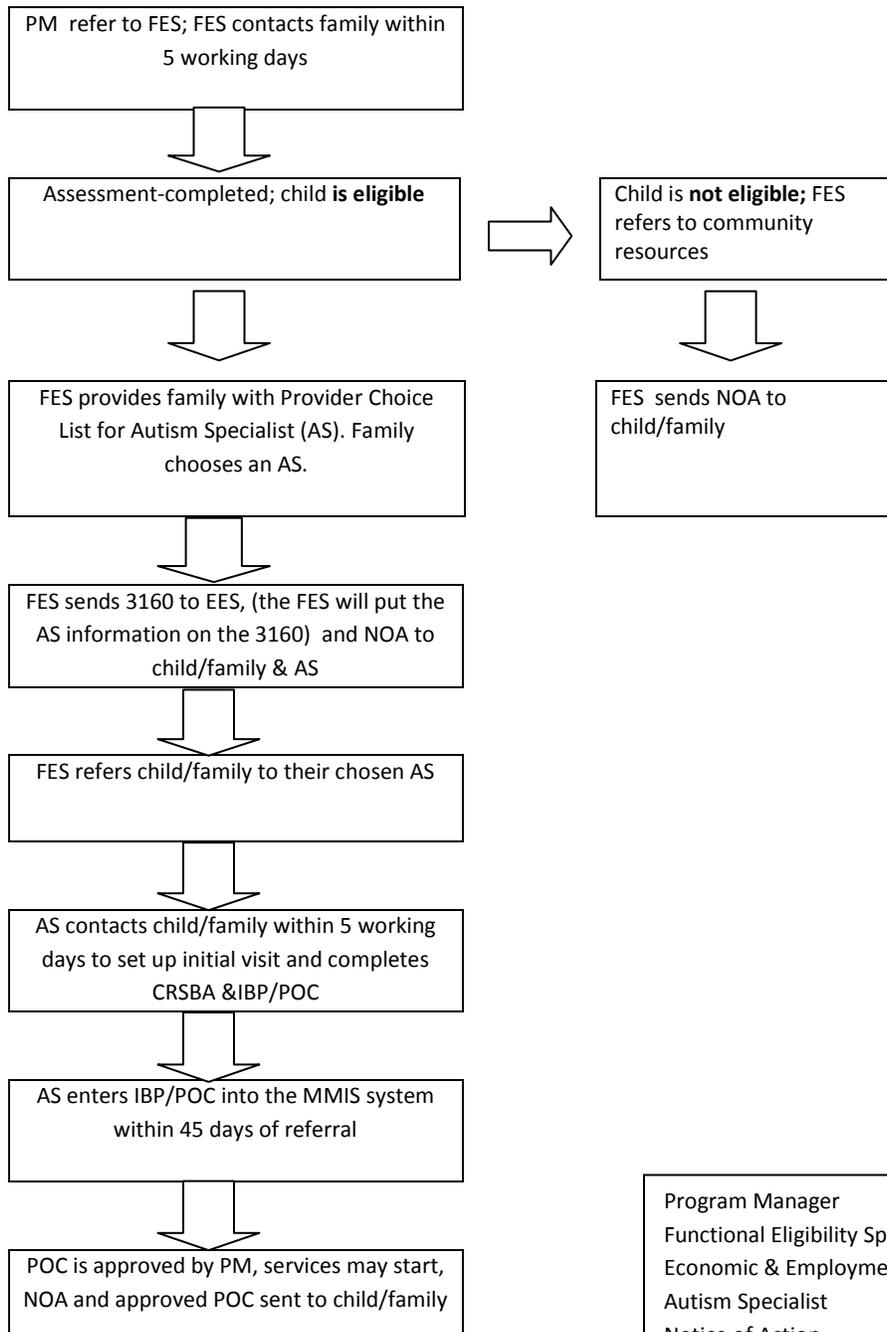
If the child's family is in the process of applying for Medicaid the Autism Specialist will contact the family. However, the criterion reference skill based assessment; IBP/POC and HCBS services will not be completed and/or implemented until Medicaid eligibility has been established.

Foster Care Contractors:

CSS understands that Foster Care Contractors do not always have available to them the necessary medical information required for different programs. Therefore, if you have a child who comes into custody and has had a diagnosis of Autism but you do not have the documentation necessary to complete the one page application and/or do not have the signature of the License Medical Doctor or Ph.D. Psychologists who made the diagnosis, then Section 2 of the application does not need to be completed at the time the application is submitted. However, you must send a statement on your organization's letterhead stating why documentation is not being submitted. (CSS will enter the child's name into the data base without the required documentation.) Your organization is still responsible for providing the required documentation that the child has a diagnosis of Autism at the time the child is offered a functional determination.

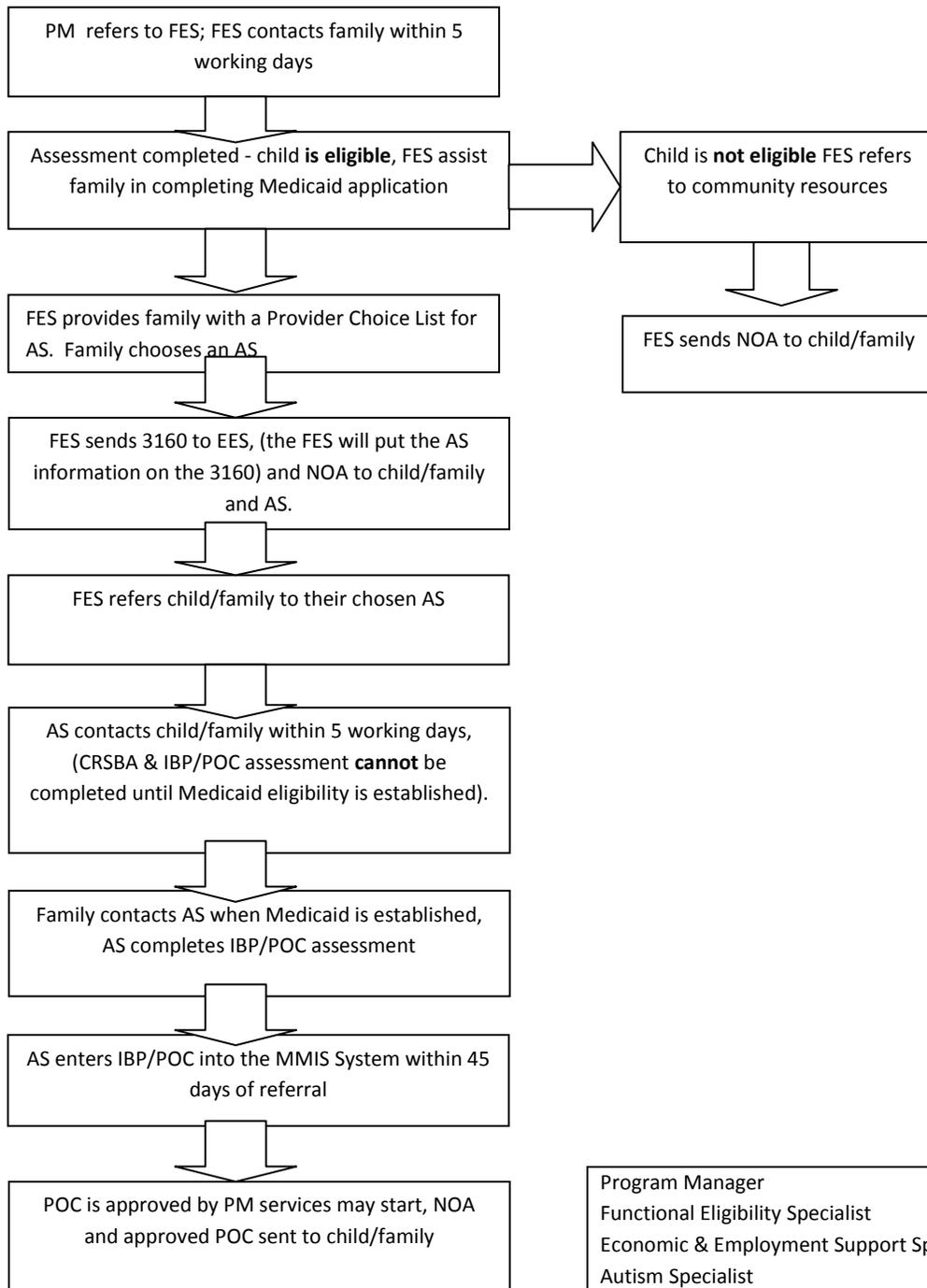
**C-7 Flow Charts**

**Medicaid Eligible Child (if a child has Health Wave they still need to complete a Medicaid Application)**



Program Manager	- PM
Functional Eligibility Specialist	- FES
Economic & Employment Support Specialist	- EES
Autism Specialist	- AS
Notice of Action	- NOA
Individual Behavioral Program/Plan of Care	- POC
Criterion reference skill base assessment	- CRSBA
Individual Behavioral Program/Plan of Care	- IBP/POC
Medicaid Management Information System	- MMIS

**Non-Medicaid Eligible Child**



Program Manager	- PM
Functional Eligibility Specialist	- FES
Economic & Employment Support Specialist	- EES
Autism Specialist	- AS
Notice of Action	- NOA
Individual Behavioral Program/Plan of Care	- POC
Criterion reference skill base assessment	- CRSBA
Individual Behavioral Program/Plan of Care	- IBP/POC
Medicaid Management Information System	- MMIS

## *Services*

The HCBS Autism Waiver service is a needs based program. These services are identified through the development of Individual Behavioral Program/Plan of Care (IBP/POC) and may be provided in all customary and usual community locations including where the child lives, and/or socializes.

For the purpose of this waiver, “family” is defined as persons who live with or provide care to a child served on the Waiver, and may include a parent, stepparent, legal guardian, siblings, relatives, grandparents, or foster parents.

There is no Crisis funding, or exceptions granted for obtaining a position or services on the HCBS Autism Waiver.

The following services cannot be provided to a child who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease.

Transportation to and from school, medical appointments, community-based activities, and/or any combination of the above is included in the rate to providers of this service.

K.A.R. 30-5-308 does not allow supplementation of HCBS services.

*All services providers, except Respite, need a National Provider Identifier (NPI). To receive additional information on NPI go to <https://www.kmap-state-ks.us/>*

### **D-1 Consultative Clinical and Therapeutic Services**

*(Submit procedure code H2015 to bill Consultative Clinical and Therapeutic Services)*

Consultative Clinical and Therapeutic Services (CCTS) are provided by the Autism Specialists, CCTS, (therapeutic is defined as working towards remediation of the behavioral symptoms related to the diagnosis of an Autism Spectrum Disorder (ASD) by teaching more adaptive skills), are intended to assist the family and paid support staff or other professionals with carrying out the Individual Behavioral Program/Plan of Care (IBP/POC) that supports the child’s functional development and inclusion in the community.

Autism Specialist Services consist of:

- Completion of a Criterion Reference Skill Based Assessment.
- Identification, with family’s input, which evidence-based treatment option will be utilized.
- Development of the IBP/POC based on the identified needs of the child with the family’s input and guidance.

## *Services*

- Training and technical assistance to the family and paid support staff in order to carry out the IBP/POC.
- Development of the teaching protocol by which the Intensive Individualized Support person implements the evidence-based treatment.
- Service Coordination and Implementation.
- Monitor the child's progress within the program.
- Utilizes data-based decision making to monitor progress, track gains, and make program modifications.

The HCBS Autism Waiver ensures all waiver services including the Autism Specialist service, will not restrict a child or family's free choice of providers in accordance with Section 1902 (a) (23) of the Act. The Service Provider Selection Summary (AW-003) is the form utilized that documents the family's choice of providers.

The Autism Specialist must supply the child/family a list of all HCBS Autism providers and allow the child/family to choose the provider of services. As new services providers become available the Autism Specialist will provide the family with a new list. Family's choice of providers, including Autism Specialist, should be reviewed at a minimum every 12 months or sooner if the family requests a change.

*Since it is important to meet the needs of the child, it is necessary that the Autism Specialist and family is a good match. Therefore, it is imperative that the family and the Autism Specialist agree upon which evidence-based therapy will be developed and implemented. In the event, the Autism Specialist and a family cannot agree, the family can choose another Autism Specialist or the Autism Specialist can recommend another Autism Specialist to work with the family. However, at no time will Autism Specialist services be discontinued or refused to a child or family due to personal conflict between an Autism Specialist and the family.*

In order for a child to gain the necessary skills required to successfully interact with their environment, the Autism Specialist should empower families to participate in the development, training, and implementation of the evidence-based therapy being utilized.

a. Provider Qualifications:

- Medicaid enrolled provider
- Master's degree, preferably in human services or education and documentation of 2,000 hours of experience working with a child with an autism spectrum disorder (ASD) OR Board Certified Behavior Analysts (BCBA) and documentation of 2000 hours experience working with a child with an Autism Spectrum Disorder\*

## *Services*

- ***Successfully complete the*** state approved curriculum, (prior to or within 6 months of being notified of being an approved Medicaid provider. It is strongly suggested that training be taken in a sequent order. CSS will be monitoring enrolled providers to ensure providers are completing the required curriculum.
  - If an Autism Specialist provider does not successfully complete the required curriculum and activities (score of at least 80%) then they have the ability to retake the on-line assessment and /or the hands-on skill fluency within two months of being notified they did not receive 80% on the first assessment(s).
  - If an Autism Specialist provider should not receive a score of 80% or more on the second on-line assessment and/or skill fluency then they will be required to have a mentor (an Autism Specialist who has successfully completed the state approved curriculum and is actively providing services on the Autism waiver) until they successfully complete the on-line assessment and/or skill fluency. The third assessment must be taken within two months of being notified they did not receive 80% on the second assessment(s). The Autism Specialist provider must successfully complete the required curriculum and activities within the above mention time frames to continue being a provider of services under the Autism Waiver.
- Must successfully pass background check with the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Kansas Dept. of Health and Environment Kansas Nurse Aid Registry, and Motor Vehicle screen.
- Must maintain all standards, certifications, and licenses required for the specific Professional field through which service is provided including but not limited to: professional license/certification, if required; and adherence to DBHS/CSS training and professional development requirements.
- Medicaid Enrolled Provider

*\*Exception policy to allow SRS to waive 1000 hours of the required experience for individuals who are BCBA.*

### Limitations:

- This service has a limitation of 200 units per calendar year, units maybe exceeded only with prior authorization from the HCBS Autism Program Manager.
- Persons with family relationships to the child/family cannot be the assigned Autism Specialist.

## *Services*

- No more than one Autism Specialist may be paid for services at any given time of day.
- Travel time is not reimbursable.

### b. Major Components for CCTS

- **Criterion Reference Skill Based Assessment (CRSBA)**

A CRSBA is completed at least annually and kept in the child's file. The CRSBA will be considered instrumental in documenting a child's progress in the HCBS Autism waiver. The criterion-referenced test measures the individual performance against defined (and objective) criteria. It is often, yet not always, used to establish an individual's competence, (whether he/she can do something). Depending upon which CRSBA is completed a child's specific skills are identify. An example a CRSBA is given below:

#### Assessment of Basic Language and Learning Skills (ABLIS)

The ABLIS is a tool for assessing skills in children with language and learning deficits and is commonly used as an initial step in the development of a behavioral program for children on the autism spectrum. Further, the ABLIS is used to track progress on critical learning skills, as compared to the child's initial performance. Examples of specific skills assessed by the ABLIS are imitation and vocalizations. The ABLIS does not compare the child to norms or the performance of other children. It assesses fundamental skills in a hierarchical sense and breaks them down into their essential components. It assess interventions that build on the abilities already possessed by the child.

The CRSBA is completed by, or under the direction of, the Autism Specialist. The Autism Specialist responsible for the CRSBA is one whom the family has chosen during the initial functional eligibility determination process from a list provided to them by the Functional Eligibility Specialist. Once the Autism Specialist has been identified they will be contacted to verify that he/she is currently accepting referrals. Once acceptance by the Autism Specialist has been verified the Autism Specialist will meet/contact with the family within five (5) working days, unless a different time frame is requested by child/family applying for services or their legal representative, if appropriate.

*Note: Since the Autism Specialist services are paid through Medicaid it is necessary the child is Medicaid eligible before the CRSBA portion and the IBP/POC is completed.*

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As soon as Medicaid eligibility is secured/verified, the Autism Specialist will complete the CRSBA. Depending upon the child and/or the age of child, the amount of time needed to complete the CRSBA may range at a minimum of 2 hours to 3 days or more. The identification of skills to be included on the IBP/POC may at a minimum take 2 to 4 hours with the family's input. After developing the IBP/POC, the Autism Specialist will proceed with the development of the teaching protocol for each skill identified on the IBP/POC. The whole process of assessment, scoring, development of the IBP/POC and program development may take between 4 to 10 days.

- **Individualized Behavioral Program/Plan of Care (IBP/POC)**

The child/family, Autism Specialist, and other sources the family has identified as being critical or important in the child's life work together in the development of IBP/POC. Since the CRSBA is the foundation from which the evidence-based therapy is developed, it also becomes the frame work for the IBP/POC. The IBP/POC incorporates information from the CRSBA and the Vineland II.

The IBP/POC is updated at a minimum of every 12 months (face-to-face) in the child/family's environment. However, the Autism Specialist is responsible for post implementation of the POC which includes monitoring and follow-up activities and a review of the IBP's Domain section at a minimum of every six months with documentation of progress toward stated goals. If progress is not demonstrated, documentation must support a reason for pursuing these goals or a change in the goals must be made. Changes in conditions that may prompt the need for changes to the services provided are identified by the Autism Specialist, family and or support team and service revisions are submitted to the HCBS Autism Program Manager for authorization.

Because Autism Waiver services cannot duplicate any services included under IDEA or the Rehabilitative Services Act of 1973 (per 1915c), the Autism Specialist will to need work with the school system in coordinating services to ensure duplication does not occur. Autism Specialist should determine the needs of the child, taking into account current mandated supports when developing the IBP/POC.

IBP/POC	<ul style="list-style-type: none"><li>• Develop IBP/POC initially and annually</li><li>• Identify functional capabilities</li><li>• Specify goals and actions utilizing an evidenced based therapy</li></ul>
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	<ul style="list-style-type: none"> <li>• Identify current resources available (formal and informal)</li> <li>• Develop, update or review Plan of Care at a minimum annually or as needed</li> <li>• Review of domains every 6 months</li> <li>• Evaluate the family’s strengths, goals, and preferences</li> </ul>
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• **C**

**Coordination and Implementation**

The Autism Specialist provides service coordination to identify, select, obtain, coordinate, and use both paid services and natural supports that may be available to enhance the child’s independence, integration, and productivity. Family members are expected to take an active role in following the IBP/POC in order to maintain consistency in the child’s environment using the evidence-based therapy.

<p>Coordination/ Implementation</p>	<ul style="list-style-type: none"> <li>• Initiate contacts and confer with child/family, providers and others identified on IBP/POC</li> <li>• Implement services identified on IBP/POC</li> <li>• Arrange for paid supports</li> <li>• Training and technical assistance to the family and paid support staff.</li> <li>• Assure effective transitioning to an HCBS waiver or to a life without services.</li> <li>• Assure collateral work with other systems, agencies, and/or persons involved in child’s life.</li> </ul>
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• **Training and Technical Assistance**

Training and technical assistance to the family and paid support staff is driven by the IBP/POC. The Autism Specialist is responsible for overseeing the evidence-based therapy that will be used for the early intensive intervention with the child. In order to accomplish this task and carry out the program the Autism Specialist will provide training and technical assistance to both the Individualized Intensive Support person (IIS), and to the family. Training and technical assistance can include but is not limited to: appropriate interventions and the collection of data regarding the interventions.

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• **Monitoring**

The Autism Specialist visits with the child/family on an as needed basis through home visits, electronic transmission (e.g., webcams, emails) phone contacts with family, IIS person, or in a team meeting setting.

Monitoring Services	<ul style="list-style-type: none"> <li>• Services are being furnished in accordance with the child’s IBP/POC</li> <li>• Services in the IBP/POC are adequate to maintain an appropriate level of care</li> <li>• Service authorizations are adequate to support the delivery of needed services</li> </ul>
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c. Autism Specialist billing:

- Autism Specialist service is billed by units of services. A unit equals 15 minutes, at a rate of \$17.50 per unit. Units are limited to 200 units per calendar year. Prior Authorization (PA) is required when a child requires more than 200 units per year, (see billing section on how to bill).
- Services are to be billed by date of service.
- Written documentation is required for services provided and billed to the Kansas Medical Assistance Program (see section G for greater details on documentation).

d. Prior Authorization for additional Autism Specialist units

- All prior authorization of additional Autism Specialist units requires Autism Program Manager’s approval.
- All requests must be received 10 days prior to the effective date of the request.
- All approval for additional Autism Specialist units are subject to needs of the child and extraordinary circumstances.

Process for requesting additional Autism Specialist units are as follows;

- Submit a request explaining the need for additional units
- Include how the units will be utilized
- Include how many units have been utilized to date
- Number of units requested

The Autism Specialist is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and/or exploitation per K.S.A. 38-2223

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### **D-2 Intensive Individual Supports**

*(Submit procedure code H2019 to bill Intensive Individual Supports)*

Intensive Individual Supports services are identified on the POC. They are services provided to a child with an ASD to assist in acquiring, retaining, improving, and generalizing the self-help, socialization, and adaptive skills necessary to reside and function successfully in home and community settings. Services are provided through evidence-based and data-driven methodologies. Intensive Individual Supports person will be trained by, work under the direction of the Autism Specialist, provide one- on-one services with the child, and document services provided.

Intensive individual supports include assisting with the development of skills such as:

- Social skills to enhance participation in family, school, and community activities (including imitation, social initiations and response to adults and peers, parallel and interactive play with peers and siblings)
- Expressive verbal language, receptive language, and nonverbal communications skills
- Functional symbolic communication system
- Increased engagement and flexibility in developmentally appropriate tasks and play, including the ability to attend to the environment and respond to an appropriate motivational system
- Fine and gross motor skills used for age-appropriate functional activities, as needed
- Cognitive skills, including symbolic play and basic concepts, as well as academic skills
- Conventional and appropriate behaviors in place of negative behavior patterns
- Independent organizational skills and other socially appropriate behaviors that facilitate successful community integration (such as completing a task independently, following instruction in a group, or asking for help)

The majority of these contacts must occur in customary and usual community locations where the child lives, has child care, and/or socializes.

a. Provider Qualifications:

- Medicaid enrolled provider
- Bachelor's degree, preferable in human services or education and documentation of 1000 hours experience working with ASD OR 60 college credit hours and documentation of 1,000 experience working with a child with an Autism Spectrum Disorder.
- Must work under the direction of the Autism Specialist

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- ***Successfully complete the*** state approved curriculum (prior to or within 6 months of being notified of being an approved Medicaid provider). It is strongly suggested that training be taken in a sequent order CSS will be monitoring enrolled providers to ensure providers are completing the required curriculum.
  - If an IIS, provider does not successfully complete the required curriculum and activities (score of at least 80%) then they have the ability to retake the on-line assessment and/or the hands-on skill fluency within two months of being notified they did not receive 80% of the first assessment(s).
  - If an IIS provider should not receive a score of 80% or more on the second on-line assessment and or skill fluency then they have the ability to retake the assessment(s).The third assessment must be taken within two months of being notified they did not receive 80% on the second assessment(s). The IIS provider must successfully complete the required curriculum and activities within the above mention time frames to continue being a provider of services under the Autism Waiver.
- Must successfully pass background check with the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Kansas Dept. of Health and Environment Kansas Nurse Aid Registry , and Motor Vehicle screen
- Must maintain all standards, certifications, and licenses required for the specific Professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS/CSS training and professional development requirements.
- Must be a KMAP –enrolled provider for intensive individual supports.

### Limitations:

- Persons with family relationships to the beneficiary cannot provide Intensive Individual Supports services.
- The Maximum allowable units per child are 100 units per week per calendar year.
- Services must be identified in the child’s IBP/POC.
- No more than one individual supports services provider may be paid for at any given time of day.
- Travel time is not reimbursable

### b. Intensive Individual Supports billing:

- Intensive Individual Support service is billed by units of service. A unit equals 15 minutes, at a rate of \$6.25 per unit. Units are limited to 100 units per week per

## *Services*

calendar year. Prior authorization is required for this service through the plan of care.

- Services are to be billed by date of service.
- Written documentation is required for services provided and billed to the Kansas Medical Assistance Program (see section G for greater details on documentation).

The Intensive individual support person is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and /or exploitation per K.S.A. 38-2223

### **D-3 Respite Care**

*(Submit procedure code T1005 to bill Respite Care)*

Respite Care services provides temporary direct care and supervision of the child. The primary purpose is to provide relief to families and caregivers of a child with ASD. The service is designed to help meet the needs of the primary caregiver as well as the identified child.

Respite Care services consist of:

- Assistance with normal activities of daily living
- Support in home and community settings

a. Provider Qualifications:

- Medicaid enrolled provider
- Must have a high school diploma or equivalent
- Must be 18 years of age or older
- Must meet family's qualifications
- Must reside outside of child's home
- Must work under the direction of the Autism Specialist
- ***Successfully complete the*** state approved curriculum (prior to or within 6 months of being notified of being an approved Medicaid provider). It is strongly suggested that training be taken in a sequent order. CSS will be monitoring enrolled providers to ensure providers are completing the required curriculum.
  - If a Respite or Parent Support & Training provider does not successfully complete the required curriculum (score of at least 80%) including the workshop then they have the ability to retake the on-line assessment within two months of being notified they did not received 80% of the first assessment.

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- If a Respite or Parent Support & Training provider should not receive a score of 80% or more on the second on-line assessment then they have the ability to retake the assessment. The third assessment must be taken within two months of being notified they did not receive 80% on the second assessment. The Respite or Parent Support & Training provider must successfully complete the required curriculum and workshop within the above mention time frames to continue being a provider of services under the Autism Waiver.
- Must successfully pass background check with the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Kansas Dept. of Health and Environment Kansas Nurse Aid Registry, and Motor Vehicle screen
- Must maintain all standards, certifications, and licenses required for the specific Professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS/CSS training and professional development requirements
- Must be a KMAP –enrolled provider for intensive individual supports

### Limitations:

- Respite care services are available to participants with a family member who serves as the primary caregiver and is not paid to provide any HCBS autism waiver service to the child.
  - Respite care cannot be provided by a parent and /or the primary care giver of the child.
  - Services must be recommended by an autism specialist, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's IBP/POC.
  - Respite care is provided in planned or emergency segments and may include payment during the individual's sleep time.
  - No more than one Respite care provider may be paid for services at any given time of day.
  - Travel time is not reimbursable.
- b. Respite care billing:
- Respite care services are billed by units of services. A unit equals 15 minutes, at a rate of \$3.00 per unit. Units are limited to 672 units per calendar year. Prior authorization is required for this service through the Plan of Care.
  - Services are to be billed by date of services.

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- Written documentation is required for services provided and billed to the Kansas Medical Assistance Program (see section G for greater details on documentation).

### **D-4 Parent Support and Training (Peer to Peer)**

*(Submit procedure code T1027 to bill Parent Support and Training at an individual rate)*

*(Submit procedure code T1027 HQ to bill Parent Support and Training at a group rate)*

Parent Support and training services promote the engagement and active participation of family members in all aspects of the treatment process. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in acquiring the knowledge and skills necessary to understand and address the specific needs of the child in relation to Autism Spectrum Disorder and related treatments. The Parent Support provider can also assist the parents in gathering materials, making materials, finding information and training parents on the materials under the direction of the Autism Specialist and Parent Support training maybe provide on a one-to-one basis or in a group setting.

Parent Support services will enhance the family's coping skills listed below:

- Specific problem solving skills
- Coping mechanisms
- Develop strategies for the child's symptom and behavior management

a. Provider Qualifications:

- Medicaid enrolled provider
- Must have a high school diploma or equivalent
- Must be 21 years of age or older
- Must work under the direction of the Autism Specialist
- Must have three years of direct care experience with an ASD child or is a parent of a child with an ASD.
- ***Successfully complete the*** state approved curriculum, (prior to or within 6 months of being notified of being an approved Medicaid provider). It is strongly suggested that training be taken in a sequent order.CSS will be monitoring enrolled providers to ensure providers are completing the required curriculum.

- If a Respite or Parent Support & Training provider does not successfully complete the required curriculum (score of at least 80%) including the workshop then they have the ability to retake the on-line assessment within two months of being notified they did not received 80% of the first assessment.

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- If a Respite or Parent Support & Training provider should not receive a score of 80% or more on the second on-line assessment then they have the ability to retake the assessment. The third assessment must be taken within two months of being notified they did not receive 80% on the second assessment. The Respite or Parent Support & Training provider must successfully complete the required curriculum and workshop within the above mention time frames to continue being a provider of services under the Autism Waiver.
- Must successfully pass background check with the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Kansas Dept. of Health and Environment Kansas Nurse Aid Registry, and Motor Vehicle screen
- Must maintain all standards, certifications, and licenses required for the specific Professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS/CSS training and professional development requirements
- Must be a KMAP –enrolled provider for Parent Support & Training

### Limitations:

- Persons with family relationships to the beneficiary cannot provide parent support and trainings services.
  - The maximum allowable units per child are 120 units per calendar year. This limit applies whether it is an individual or group rate or a combination of individual and group services.
  - Services must be recommended by an Autism Specialist, are subject to prior approval through the Plan of Care, and must be intended to achieve the goals or objectives identified in the child’s IBP/POC.
  - Group settings cannot consist of more than three families.
  - The group membership requirement for parent support and training is to have a family member with a diagnosis of an ASD.
  - Families must agree to a group setting.
  - No more than one Parent Support provider may be paid for services at any given time of day.
  - Travel time is not reimbursable.
- b. Parent Support and Training billing:
- Parent Support services are billed by units of services. A unit equals 15 minutes whether it is an one on one or a group setting. The rate for an individual is

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\$6.25 per unit and the rate for group setting is \$3.00 per unit per family. Units are limited to 120 units per calendar year. Limitation on units is the same whether services are given individually, group, or a combination of both.

- Services are to be billed by date of services
- Written documentation is required for services provided and billed to the Kansas Medical Assistance Program (see section G for greater details on documentation).

## **D-5 Family Adjustment Counseling**

*(Submit procedure code S9482 to bill Family Adjustment Counseling for an individual rate)*

*(Submit procedure code S9482 to bill Family Adjustment Counseling for a group rate)*

Counseling can be provided to the family members of a child with an Autism Spectrum Disorder in order to guide and help them cope with the child's illness and the related stress that accompanies the initial understanding of the diagnosis and the ongoing continuous, daily care required by the child with an Autism Spectrum Disorder. Enabling the family to manage this stress improves the likelihood that the child with the disorder will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. When acceptance of the disorder is achieved the family is better prepared to support the child on an ongoing basis. Services can be provided on a one-to-one basis or in a group setting.

Family Adjustment Counseling services:

- Is responsible for maintaining an ongoing collaborative relationship with the Autism Specialist beginning at the time of the referral.
- Offers the family a mechanism for expressing emotions associated with the comprehension of the disorder.
- Allows families to ask question about the disorder in a safe and supporting environment.
- Will provide the Autism Specialist a treatment plan, including the frequency, length, and duration of sessions.

a. Provider Qualifications:

- Medicaid enrolled provider
- Licensed Mental Health Professional (LMHP) by the State of Kansas.
- Must successfully pass background check with the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Kansas Dept. of Health and Environment Kansas Nurse Aid Registry, and Motor Vehicle screen

## *Services*

### Limitations:

- Persons with family relationships to the beneficiary cannot provide family adjustment counseling services.
- The maximum allowable units per child are 48 units per calendar year. This limit applies whether it is individually or group rate or a combination of individual and group services.
- Services must be recommended by an Autism Specialist, are subject to prior approval through the plan of care process.
- Must be intended to achieve the goals or objectives identified in the child's IBP/POC.
- A group setting cannot consist of more than three families.
- The group membership requirement for family adjustment counseling is to have a family member with a diagnosis of ASD.
- Families must agree to a group setting.
- No more than one Family Adjustment Counselor may be paid for services at any given time of day.

The Family Adjustment Counselor is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and /or exploitation per K.S.A. 38-2223

### Family Adjustment Billing:

- Family Adjustment Counseling service is billed by units of service. A unit equals 15 minutes. The rate for an individual is \$10.00 per unit and the rate for a group setting is \$5.00 per unit per family.
- Services are to be billed by date of services
- Written documentation is required for services provided and billed to the Kansas Medical Assistance Program (see section G for greater details on (documentation)).

## **D-6 Interpersonal Communication Therapy**

*(Submit procedure code G0153 to bill Interpersonal Communication Therapy*

Interpersonal Communication Therapy (ICT) services remediate social communications symptoms related to the diagnosis of an autism spectrum disorder and will be provided through evidence based methodologies. The Autism Specialist is the entity that identifies needed services and the providers for meeting those needs through the development of an individualized plan of care. This tool (the Individualized Behavioral Program/Plan of care (IBP/POC) is used to delineate the specific objective/goals which the various team members are to work. The Plan of Care (approved by State Staff) will delineate the role of the specialist providing the ICT services, such as the ongoing evaluation and

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identification of the necessary communication needs of the child. When appropriate, the Autism Specialist will coordinate with the Interpersonal Communication Therapy provider to identify those needs and develop goals in those areas. The ICT provider has specific training and education in the area of communication and therefore can provide specific direction in those areas. When specific deficits are identified, the ICT provider will initiate these targeted interventions. The Intensive Individualized Support (IIS) is the identified provider who will implement the ongoing interventions identified in the IBP/POC by the Autism Specialist. Where appropriate the Autism Specialist will consult with the ICT provider to ensure that the IIS provider is trained in any specialized techniques specific to the communication needs of the child.

Interpersonal Communication Therapy services:

- Teaching conversational skills;
- The initiation of spontaneous communication in functional activities across social partners and settings;
- The comprehension of verbal and nonverbal discourse in social and community settings;
- Communication for a range of social functions that are reciprocal; and
- The development of a functional communication system.

The majority of these contacts must occur in customary and usual community locations where the child lives, goes to child care, and /or socializes.

a. Provider Qualifications:

- Medicaid enrolled provider
- Licensed Speech Pathologist with a certificate of Clinical competence from the American Speech and Hearing Association.
- 1,000 hours experience working with a child with an Autism Spectrum disorder
- Completion of state approved curriculum (prior to or within 6 months of being notified of being an approved Medicaid provider) CSS will be monitoring enrolled providers to ensure providers are completing the required curriculum.
- ***Successfully complete the*** state approved curriculum, (prior to or within 6 months of being notified of being an approved Medicaid provider). It is strongly suggested that training be taken in a sequent order. CSS will be monitoring enrolled providers to ensure providers are completing the required curriculum.
- If an Interpersonal Communication Therapy (ICT) provider does not successfully complete the required curriculum and activities (score of at least 80%) then they have the ability to retake the on-line assessment and /or the

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hands-on skill fluency within two months of being notified they did not receive 80% on the first assessment(s).

- If an ICT provider should not receive a score of 80% or more on the second on-line assessment and/or skill fluency then. The third assessment must be taken within two months of being notified they did not receive 80% on the second assessment(s). The ICT provider must successfully complete the required curriculum and activities within the above mention time frames to continue being a provider of services under the Autism Waiver.
- Must successfully pass background check with the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Kansas Dept. of Health and Environment Kansas Nurse Aid Registry, and Motor Vehicle Screen.
- Must maintain all standards, certifications, and licenses required for the specific [professional field through which service is provided including but not limited to: professional license/certification if required; adherence to DBHS/CSS training and professional development requirements
- Must be willing to work with all members of the autism waiver team

### Limitations:

- The maximum allowable units per child are 8 units per week per calendar year.
  - Services must be recommended by an Autism Specialist and Physician; a Drs. order must be written for services and maintained in the child's file.
  - Services must be identified in the child's IBP/POC.
  - No more than one ICT provider may be paid for at any given time of day.
  - Travel time is not reimbursable
  - Persons with family relationships to the beneficiary cannot provide services Interpersonal Communication Therapy.
- b. Interpersonal Communication Therapy billing:
- Interpersonal Communication Therapy service is billed by units of service. A unit equals 15 minutes, at a rate of \$ 17.46 per unit. Units are limited to 8 units per week per calendar year. Prior authorization is required for this service through the plan of care.
  - Services are to be billed by date of service.
  - Written documentation is required for services provided and billed to the Kansas Medical Assistance Program (see section G for greater details on documentation).

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The Interpersonal Communication Therapy provider is expected to adhere to federal and state regulations regarding reporting of abuse, neglect, and /or exploitation per K.S.A 38-2223.

### **D-7 Reimbursable Services for Providers**

- Completion of the Criterion Reference Skill Based Assessment (initial & annually)
- Interpersonal communication evaluation
- Interpersonal communication skill building
- Development of the IBP/POC (initial & annually)
- Service Coordination and Implementation as identified per IBP/POC
- Monitoring of Services
- Completing the necessary forms required by SRS
- Home visits
- Contacts may include but not limited to; phone, email, and/or letters providing documentation supports services rendered are coordination and/or implementation of Autism Waiver services.
- Training and technical assistance to parents and paid support staff
- Assistance with activities of daily living

### **D-8 Waiver Services Limitations**

Since Kansas has chosen to focus on an HCBS Autism early intensive intervention Waiver in order to have a greater impact on the lives of those children with an Autism Spectrum Disorder these services are limited to 3 years unless medically necessary. At the end of three years, if the Autism Specialist and family believe it is medically necessary to continue with waiver services because the child has demonstrated continued improvement and would likely to continue to improve with the extension, a request for a one time, one year extension can be made.

There is no Crisis funding, or exceptions granted for obtaining a position on the HCBS Autism Waiver. However, a child from another waiver could transfer to the Autism Waiver, providing the child meets the guidelines set forth.

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**D-9 Criteria for determining Medical Necessity for one year, one time extension.**

Medical Necessity Criteria:

1. Individualized Behavioral Program / Plan of Care (IBP/POC) - section 1, question 11 - (Global Risk Rating scale) on the most recent IBP/POC. This question asks parents to rate their child's behavior in relationship to their environment(s). A minimum total score of 14 has to be met.

2. Did the family use 2 services (must meet): if not, why not?

3. A child must have utilized at least 20% of available waiver services in the last 365 days prior to the request for extension of services in order to demonstrate a need of continued services. The calculations for the 20% can span across two calendar years.

*(MMIS data will verify usage of services per paid claims).*

4. Compare Adaptive skills from the initial Vineland to the most recent Vineland and the child must show improvement in any 2 adaptive skills, (raw scores)

Adaptive skills are;

- a. Communication
- b. Daily Living skills
- c. Socialization
- d. Motor skills

5. If the child does not meet the criteria for items 3 or 4, listed above, the team can use one or a combination of the following items as a determining factor to demonstrate a continue need for services;

- a. Criterion Reference Skill Based Assessment (CRSBA) summary
- b. additional data sheet
- c. progress sheets

**D-10 Extension request**

It is the Autism Specialist responsibility to request and make available all documentation necessary for the review team to make a decision. The Autism Specialist will complete the Request of Extension /Statement of need form, (AW-008). All requests for the one time one year extensions of HCBS Autism Waiver services must be submitted to the

## *Services*

Autism Waiver Program Manager no later than 120 days before the child meets their service limits.

Example – (how to calculate the deadline for submitting extension request, when a child has met their 3 year service limit);

*Johnny was offered an Autism Waiver position on 1/17/2008 and his initial Vineland assessment was completed on 1/21/2008. His request for the fourth year extension would need to be submitted to the Autism Program Manager no later than 9/24/2010.*

The Autism Review team will consist of the HCBS Autism Program Manager, a therapist/ individual who works with children with autism and an Autism Specialist who is not directly involved with the child/family requesting the extension. Although this is team review, CSS retains the right to make the final decision as to whether an extension will be granted. Therefore it will be CSS responsibility for sending the Notice of Action notifying the family and Autism Specialist of the final decision.

- a. Required documentation for an extension request:
- All Vineland Scores & Criterion Reference Skill Assessment summaries
  - Current IBP/POC
  - Progress reports for the past six (6) months and
  - Signed Statement of Need (AW-008)

### **D-11 How to bill for HCBS Autism Services**

Time Keeping:

Time must be totaled by actual minutes/hours worked. Billing staff may round the total at the end of the billing cycle to the nearest one-half unit. One unit = 8 through 15 minutes; one-half unit (.5 unit) = up to and including 7 minutes. Providers are responsible to ensure the services were provided prior to submitting claims.

Client Obligation:

If an Autism Specialist has assigned client obligation to a particular provider and informed that provider to collect this portion of the cost of service from the client, the provider does not reduce the billed amount on the claim by the client obligation because the liability will automatically be deducted as claims are processed.

**Note:** Client obligation is assigned only to the HCBS Autism Waiver services included on the MMIS Plan of Care.

## *Services*

### One Plan of Care per Month:

Prior authorizations through the Plan of Care process are approved for one month only. Dates of service that span two months must be billed on two separate claims.

### Example:

Services for July 28-August 3 must be billed with July 28-31 on one claim and August 1-3 on a second claim.

### Overlapping Dates of Service:

The dates of service on the claim must match the dates approved on the Plan of Care and cannot overlap. For example, there are two lines on the Plan of Care with the following dates of service:

July 1-15 and July 16-31. If a provider bills service dates of July 8-16, the claim will deny because the system is trying to read two different lines on the Plan of Care. For the first service line, any date that falls between July 1-15 will prevent the claim from denying for date of service.

### Same Day Service:

For certain situations, HCBS waiver services approved on a Plan of Care and provided on the same day a beneficiary is hospitalized or in a state mental hospital may be allowed. Situations are limited to HCBS waiver services provided on the date of admission, if provided prior to the beneficiary being admi

*Services*

**D-12 Autism Chart of Services**

H2015 (will need NPI number)	CCTS – Autism Specialist	\$70 per hour	50 hours per calendar year or 200 units at 17.50 per unit
H2019 (will need NPI number)	Intensive Individual Supports	\$25 per hour	25 hours per week = 1,300 hours per calendar year Or 100 units per week at 6.25 per unit
T1005	Respite	\$12 per hour	7 days per calendar year = 168 hours calendar per year or 672 units at 3.00 per unit.
T1027 (will need NPI number)	Parent Support & Training	\$25.00 per hour (Individual rate)	30 hour per calendar year or 120 units at 6.25 per unit.
T1027 HQ (will need NPI number)	Parent Support & Training	\$12.00 per hour (Group rate)	Limit will still apply whether it is group or individual, (\$3.00 per unit)
S9482 (will need NPI number)	Family Adjustment Counseling	\$40.00 per hour (Individual rate)	12 hours per calendar year or 48 units at 10.00 per unit
S9482 HQ (will need NPI number)	Family Adjustment Counseling	\$20.00 per hour (Group rate)	Limit will still apply whether it is group or individual (\$5.00 per unit)
G0153 (will need NPI number)	Interpersonal Communication Therapy	\$69.84 per hour	2 hours per week = 104 hours per calendar year Or 8 units per week at \$17.46 per unit.

## **E-1 Individualized Behavioral Program**

All applicants for HCBS Autism waiver services who receive a diagnosis of an Autism Spectrum Disorder (ASD), ASD includes Autism, Asperger Syndrome and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS), from a licensed Medical Doctor or PhD Psychologist using an approved Autism specific screening tool, must undergo an assessment to determine level of care (functional) eligibility for the waiver. Once a child has been determine to meet the functional eligibility the family is referred to the Autism Specialist of their choice. It is the Autism Specialist's responsibility to complete the Criterion Reference Skill Based Assessment and the Individualized Behavioral Program/Plan of Care, (IBP/POC).

The Autism Specialist along with the family and whomever the family has identified as being critical or important in the child's life develops an IBP/POC that supports the child's functional development and inclusion in the community. Keeping in mind the Criterion Reference Skill Based Assessment is the foundation from which the evidence based therapy is developed so it also becomes the frame work for the IBP/POC. The IBP/POC is the instrument that identifies general demographics on the child, Autism Specialist information, which evidence-based therapy will be used, behavior impact rating tool, global risk rating skill, services needed for the child, what skills the child currently displays and at what level, what is needed to improve those skills, the objective, plan for generalization, circle of friends, and finally the Plan of Care.

The IBP/POC is completed at a minimum annually, face to face. Post implementation of the POC includes monitoring and follow-up activities and a review of the IBP/POC at a minimum of every six months with documentation of progress toward stated goals. If progress is not demonstrated, documentation must support a reason for pursuing these goals or a change in the goals must be made.

The IBP/POC is broken into 5 sections that must be completed; the following gives an overview of each section.

- **Section I** - Provides demographics on the child, indicates the treatment option that will be used, contains a behavioral impact rating tool, a global risk rating scale, as well as asking parents to identify their 5 highest priorities they would like to have addressed.
- **Section II** - Addresses the 12 life domains in a child's life. Under these domains the Autism Specialist with the family's input identifies the child/ family needs and strengthens, supports needed for the child, current level of performance, supportive skills, objectives, and plan for generalization across all domains.
- **Section III** - Circle of Support identifies emergency contacts, list the members of the child's household and any additional non-waiver support/services from family, friend, neighbor, or church.

- **Section IV-** Plan of Care identifies the amount of services needed to meet the needs of the child, name of the provider and provider number, procedure code, services dates, number of units, rate of units, frequency of services, start and end dates for the POC, monthly cost of services, and child's obligation amount if applicable. Parent or guardian's signature is required on the plan of care. Their signature certifies that they agree to and helped develop this plan of care.
- **Section V-** Any person (except for the parents) involved or provided input into the development of the IBP/POC are required to sign the participant's signature page.

## **E-2 Plan of Care**

An individual written Plan of Care (POC) will be developed by the Autism Specialist and will describe services to be furnished, their frequency, and the type of provider who will provide each service. The POC for an Autism waiver child will contain those services identified in the IBP that supports the family and child's functional development and inclusion in the community. The following criteria will be used for the POC:

1. When figuring the number of units, frequency, and cost of services for the POC the Autism Specialist will calculate services based on 31 days. The MMIS reads electronic POC's on a monthly cost.
2. POC's are valid for a one year period and require the parent/guardian's signature annually. Any changes that may occur during the year to the paper POC will need the Autism Specialist initials and date beside those changes. All changes to the paper POC will need to be reflected on the electronic POC as well.
3. POC's must be entered into the MMIS system no later than 45 days after the child has been determined eligible for the HCBS Autism Waiver by the Functional Eligibility Specialist. If Medicaid eligibility determination is the reason for the delay, the Autism waiver Program Manager will look at each case separately
4. Services listed on the POC are based on the needs of the child and should not be placed on the POC unless they will be utilized.
5. All Autism waiver services except the Autism Specialist are listed on the POC.
6. Formal supports should always be listed on the paper POC. Non-waiver services are listed in Section III (Circle of Support).
7. The Autism Specialist will be the one entering the POC's into the Medical Management Information System (MMIS). If the Autism Specialist works for an

agency then the agency can delegate a staff person to enter the POC's into the MMIS for the Autism Specialist, keeping in mind that the Autism Specialist is ultimately the responsible party for the accuracy of the POC's.

8. The Autism Program Manager must prior authorize Plans of Care.
9. The cost of the entire POC must be equal or greater than the client obligation or the child does not meet eligibility requirements (see KEESM 8270.2).
10. When transferring waiver cases from one Autism Specialist to another it will be necessary to coordinate the closing and opening dates from one Autism Specialist to another since neither Autism Specialist will be able to see the POC on the MMIS from another Autism Specialist, it will be necessary to send case files ASAP to the receiving Autism Specialist providing all releases are completed.

### **E-3 Client Obligation**

The client obligation will be recorded on both the electronic and paper POC. The Autism Specialist should review the POC with the parent and identify to which service provider the client obligation is to be applied to. The following criteria should be used:

1. Whenever possible, the entire client obligation should be applied to a single service provider.
2. To the greatest extent possible, IIS services should be used to meet the client obligation. If these services do not fully meet the client obligation, then another waiver service may be used in conjunction with the IIS services to meet the client obligation.

Only the SRS EES Specialist can adjust the monthly client obligation amount. If the EES Specialist makes any changes to the monthly client obligation, it is their responsibility to notify the Autism Specialist using the ES-3161 form. *(This form can be found in Appendix I)*

Using a NOA, *(AW-007) this form can be found in Appendix I)*, the Autism Specialist shall notify the family to which service provider the client obligation will be paid.

The Autism Specialist shall notify the service providers of any client obligation or adjusted obligation that is to be applied toward their service in writing using the same NOA indicated above. The service providers are responsible for collecting the client obligation directly from the family.

Client obligations cannot be prorated on the POC.

The MMIS Prior Authorization (PA) must accurately reflect the amount of the client obligation and must accurately document to which provider the obligation is applied.

The Autism Specialist cannot open a HCBS Autism waiver case if the client obligation exceeds the cost of the POC.

#### **E-4 Prorating Plan of Care**

A POC beginning in the middle of the month must be prorated.

Example: A child receives 23 hours (92 units) of IIS services per week. For services beginning in mid-month, such as on January 15, the Autism Specialist would divide 23 by 7 to conclude there are approximately 3.3 hours (13.2 units) used per day. This number is then multiplied by the remaining days in the month (in this case 16), resulting in a total of 52.8 hours (232.8 units).

$$23 \div 7 = x \ 16 = 232.8 \text{ units}$$

#### **E-5 Medicaid Management Information System Prior Authorization**

The POC should be submitted for authorization to the Medicaid claim processing (fiscal) Agent via the Medicaid Management Information System (MMIS) computer program. The MMIS PA system is a provider payment system that is used to enter HCBS Autism POCs and is accessed through the fiscal agent. Because this system is linked to the Medicaid claim processing system, the PA system can automatically pull information from the MMIS to add to the POC. Information that automatically comes from the MMIS includes beneficiary name and eligibility, client obligation, provider information, provider specialty codes and allowed amounts. In addition, the PA system tracks information for the state.

1. All POCs must be submitted to the Autism Program Manager for authorization. The Program Manager will review all POCs submitted by the Autism Specialist and ensure that the information on the computerized POC is consistent to allow authorization for Medicaid payment to providers listed on the plan. POCs are reviewed against an established protocol by the Quality Assurance staff for the following:
  - a. Accuracy of information (e.g. eligibility codes, dates, and client obligation);

- b. Completeness of fields within the document;
  - c. Child and provider eligibility;
  - d. Correct mathematical calculations for frequency of monthly services including correctly prorating the cost of services;
2. Any time the POC changes, a system POC must be re-authorized. POC changes may include, but are not limited to a change in service, client obligation amount, the Autism Specialist or a provider's services end. POCs that do not begin on first day of the month will have to be prorated for Medicaid eligibility requirements.
  3. All MMIS POCs should be authorized within 5 working days of receipt provided there are no concerns identified that require time for resolution.
  4. Concerns identified on the MMIS POC will be referred back to the Autism Specialist.

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Documentation of the who, what, when, where, why and how of a child’s case must be included in the file. Documentation must be legible, accurate and completed in a timely manner and cannot be altered or created after the fact. Documentation must show how the services being provided relate to the goals and the progress of the child in reaching those goals and stand on its own. Documentation must meet the standards set forth in the Autism provider manual which is published by the Medicaid Fiscal Agent <https://www.kmap-state-ks.us/public/homepage.asp>

**F-1 Who, What, When, Where and Why of Documentation**

- a. **Who** was involved?
- b. **What** service was provided?
  - Type of service provided
    - E.g., Consultative Clinical and Therapeutic Services (CCTS, Autism Specialist), Intensive Individual Support (IIS), Parent Support and Training (PST), Respite, Family Adjustment Counseling (FAC).
  - Description of service type:
    - Observations, feedback to the IIS, program planning, time spent working on the Individual Behavioral Program/Plan of Care goals, family support, etc.
- c. **When** was the service delivered?
  - Date (month, day, year)
  - Start time/end time, am/pm, military time and length of service
- d. **Where** was the service provided?
  - Home, community, phone consultation (add office?)
- e. **Why** was the service delivered?
  - To achieve goals
  - Progress the child has made
  - Facts and evidence
- f. **How** the services will be:
  - Implemented
  - Monitored
    - Data collection
    - Parent report
    - Facts and evidence
  - Re-evaluated
    - Follow-up
    - Next steps

*NOTE: When a service is not documented or documentation is not legible or complete, services may not be reimbursed. In the case of a post-pay review, reimbursement may be recouped if documentation is not complete.*

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**F-2 Documentation Requirements**

All documentation (record keeping & retention of files) must meet the standards set forth in the provider manual published by the fiscal agent. See the Kansas Medical Assistance Program (KMAPP) web site at: <https://www.kmap-state-ks.us/public/homepage.asp>

- a. Records maintained by the Autism Specialist, Functional Eligibility Specialist, Interpersonal Communication Therapy, Intensive Individualized Supports, Respite, Parent Support & Training and Family Adjustment Counseling Services billing for services must meet the requirements for audits which may be conducted by any federal or state agency.
- b. All activities related to Autism Specialist, Functional Eligibility Specialist and other providers billable services must be specific and noted in the case file.
- c. Each entry in the case file must be signed and dated by the Autism Specialist, Functional Eligibility Specialist or other HCBS provider who provides a service. The amount of time spent providing the services must also be documented.
- d. Each case file must include the following information:
  - i. The date of the initial referral and all completed assessments & addendums
  - ii. Record of all contacts to the child and related to the child's IBP/POC (phone calls, home visits, provider contacts and reasons for contact)
  - iii. Pertinent facts that include descriptive non-judgmental language
  - iv. Letters and Notices of Action with date sent and copies noted
  - v. Changes of Autism Specialist or other providers
  - vi. Client obligation issues or changes in obligation, when applicable
  - vii. Child or family evaluation and monitoring to assure services are according to the IBP/POC.
  - viii. Changes in the IBP/POC and formal or informal support systems, with the child's or family's approval noted
  - ix. A signed copy of the Child or Family Choice, Rights and Responsibilities
  - x. Received and sent ES-3160s and ES-3161s

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- xi. Documentation of child absences from the home
- xii. All referrals made and to whom, including follow-up information
- xiii. Initial and all subsequent annual transition plans
- xiv. Signed and dated exchange of information forms indicating permission to exchange information with the party specified on the form.

**F Notice of Action**

- a. The Functional Eligibility Specialist will complete and send an NOA to each child/family after a functional eligibility determination/re-determination has been made.
- b. Upon authorization for Autism services from the Autism Program Manager, the Autism Specialist will notify the child or parent/guardian (if applicable) and service providers of the authorization using the NOA form. (See Section K for an example of this form.)
- c. When there is a change in the child's IBP/POC the Autism Specialist will send NOAs to the child or parent/guardian (if applicable) and service providers affected by the change. If a change results in any adverse action to the child the Autism Specialist will utilize the NOA form, giving the child or family ten (10) calendar days, notice, plus one (1) day for mailing, plus one (1) day for receiving mail before the change is made.
- d. An NOA that is provided to the child and relevant parties (when the child is determined eligible/re-determination or not eligible for Autism services) must include:
  - i. Date of the Notice of Action
  - ii. Child's name and address
  - iii. Autism Specialist's name, address and phone number
  - iv. Child's Medicaid identification number
    - (1) The type of services being purchased or provided
    - (2) The name of all service providers
    - (3) The effective date of eligibility and period of time eligibility will cover
  - v. The comments, message or explanation of action which includes:

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- (1) The statement of the intended action
  - (2) The hours of the service to be received daily or weekly
  - (3) The names of the persons and service providers copied
- vi. The specific manual Kansas Economic and Employment Support Manual (KEESM)
  - vii. The effective date of the intended action
  - viii. The signature of the Autism Specialist.
- e. An NOA is provided when a change in status occurs and must include the following:
- i. Date of the Notice of Action
  - ii. Child's name and address
  - iii. Autism Specialist's or Functional Eligibility Specialist name, address and phone number
  - iv. Child's Medicaid identification number
  - v. IBP/POC
    - (1) The type of all services being purchased or provided by change
    - (2) The name of all service providers affected by the change
    - (3) The effective date of the change and period of time eligibility will cover, allowing for ten (10) calendar days plus one (1) day for mailing plus one (1) day for receiving mail for adverse action
  - vi. The comments, message or explanation of action which includes:
    - (1) The statement of the intended action and indication that all other services will remain the same
    - (2) The hours of the service to be received daily or weekly
    - (3) The names of the persons and service providers copied
  - vii. The specific manual (KEESM or this manual) reference supporting such action.
  - viii. The effective date of the intended action
  - ix. The signature of the Autism Specialist or Functional Eligibility Specialist

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- x. Examples of changes in status include, but are not limited to, the following:
  - (1) Admission to and stay in a hospital for a sufficient duration to disrupt waiver services
  - (2) Additional services that may have been denied
  - (3) Service transfers to another provider, county or waiver program
  - (4) An increase or decrease in services
  
- f. If the Autism Specialist is notified of an interruption in service, an NOA will be sent to the provider informing them of the break in service.
  
- g. Failure of the child or family and/or the Autism Specialist to notify Medicaid providers of a child's change in status can result in an overpayment to providers and action may be taken to recoup payments.
  
- h. All providers who are affected by the action must be notified and sent a copy of the NOA.
  
- i. An NOA provided to a child or family determined ineligible for HCBS Autism services must include the following:
  - i. Date of the Notice of Action
  
  - ii. The child's name and address
  
  - iii. The Autism Specialist's name address and phone number
  
  - iv. The comments, message or explanation of action which includes:
    - (1) A statement of the intended action
    - (2) The reason for which the individual was determined to be ineligible including:
      - (a) Not a current recipient of SSI, or Medicaid or medical only; or
      - (b) No medical need; or
      - (c) Income and/or resources exceed eligibility limits; or
      - (d) Contact with applicant lost; or
      - (e) Applicant withdrew application
      - (f) The specific manual reference supporting such action
      - (g) The effective date of the intended action, allowing for ten (10) business days notice, plus one (1) day for mailing, plus one (1) day for receiving mail and

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- (h) The signature of the Autism Specialist or the Functional Eligibility Specialist.

*NOTE: Consumer Rights and Responsibilities must always be included on the back of the NOA, along with the individual's right to request a fair hearing*

**F-4 Transferring case files or services to another agency or service provider**

Families can choose to change a service provider any time they feel it would be appropriate. If a family wants to change a service provider of Consultative Clinical and Therapeutic Services (Autism Specialist) the family must contact the Autism Program Manager to make that request. For other service providers such as IIS, Interpersonal Communication Therapy (ICT), PST, Respite, and/or Family Adjustment Counseling the family must inform the Autism Specialist.

**Process for transferring cases:**

*Assuming appropriate releases of information are in place:*

- a. The sending Autism Specialist will contact the receiving Autism Specialist. To ensure uninterrupted services, discussions must include 1) type of services provided, 2) what will be the end date of services for the sending Autism Specialist and 3) what will be the start date of services for the receiving Autism Specialist.
- b. Once the dates have been determined each Autism Specialist will send the appropriate forms to their local SRS office (3161-sending Autism Specialist to close their case and 3161-receiving Autism Specialist to open their case).
- c. If a child or family chooses to change their Autism Specialist or service provider, they must secure services by a qualified, eligible provider within thirty (30) days of closing their case or ending services with their current provider. The parent and/or current Autism Specialist must advise the Autism Program Manager of case closure or transfer.
- d. When a request has been made by the family to change their Autism Specialist provider and another Autism Specialist provider has accepted the HCBS Autism case, all documentation including, but not limited to, will be sent from the sending Autism Specialist within two (2) weeks of the date of notification of transfer to the receiving Autism Specialist:
  - i. IBP/POC for the past 12 months (AW-004)
  - ii. Interventions that have been put in place
  - iii. All original Vineland II protocols (keep a copy for your files)

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- iv. All Notice of Actions for the past 12 months. (AW-007)
  - v. Current Choice Form for HCBS (AW-001)
  - vi. Current release of Information Form (AW-002)
  - vii. Current service provider selection form (AW-003)
  - viii. Copy of the initial ES-3160 form
  - ix. All ES-3161 forms for the past 12 months
  - x. Progress and program logs/notes for the last 3 months, QA will need documentation that reflects implementation of goals and strategies identified in the current IBP/POC.
- e. If the receiving Autism Specialist does not receive the above mentioned information within two weeks of receiving a release of information form from the child/parent(s)/guardian then the receiving Autism Specialist should be informing the Program Manager.

*(The Autism Specialist documentation should reflect the Autism Specialist efforts in obtaining the required documentation).*

- f. When a service provider of other services such as IIS, ICT, PST, Respite and/or Family Adjustment Counseling is changed, the Autism Specialist is responsible for ensuring the electronic Plan of Care is updated with current provider numbers so providers can be paid.

## F-5 Service Discharge

The following are codes for Autism Waiver service discharge:

1. Death of child
2. Child and/or family moved out of state. If they move within the state but out of the Autism Specialist service area, the child's case remains open and the case file will be transferred within 30 days to the Autism Specialist of their choice who operates in the area to which the child and family has moved.
3. Child or family chose to terminate services, including revoking release of information.
4. Family or informal support will provide the level and/or intensity of services needed.
5. Child no longer meets financial eligibility (loss of Medicaid eligibility).
6. Child no longer meets Autism functional eligibility criteria at annual re-evaluation.

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- 7 Lack of cooperation to the point that the child and/or family substantially interfere with the provider's ability to provide services, (e.g., inability to get along with providers or inappropriate child and/or family behaviors). All other options (i.e., training, counseling, etc.) must be explored prior to termination of services.
8. Family failed or refused to sign or abide by the plan of care.
9. Child and/or family whereabouts are unknown (e.g., post office returns agency mail to the child or family indication no forwarding address).
- 10 If the child and/or family have sought medical/behavioral treatment outside the state of Kansas and the treatment process will be more than thirty (30) consecutive days outside the state, the case will be closed.
11. Child has met the service limits established in the HCBS Autism Waiver.



### **G-1 Transitioning to another HCBS Waiver**

The following is the process for transitioning children who will be exiting the HCBS Autism Waiver due to meeting the three (3) year service limitation for waiver Services, or if the child had received the one time extension for an addition year and the child will require additional waiver services. The family may choose to transition the child to the HCBS/ Severe Emotional Disturbance (SED) waiver administered by Community Mental Health Centers (CMHC's) or HCBS/Mental Retardation/ Developmental Disability (MRDD) administered by Community Developmental Disability Organization (CDDO'S), providing the established criteria for each waiver are met by the child. The Autism Specialist will contact the appropriate agency six (6) months prior to the child transitioning off the HCBS Autism waiver to develop a transition plan to the appropriate waiver.

- The Autism Specialist will start transitional planning with the child and all parties involved 6 months prior to the child exiting the Autism Waiver.
- The above mention waivers could start services as soon as the date after the Autism Waiver end.
- The HCBS/SED or the HCBS/MRDD Targeted Case Manager shall submit the start date and the new Plan of Care to HCP/CSS for approval on or before the effective date of the transfer.

### **G-2 Autism Specialist Responsibilities**

The following identifies the responsibilities of the Autism Specialist in the transitioning process in order for the child/family to experience a smooth transition.

- The Autism Specialist should be discussing and explaining to the family the difference and type of services available from the above mention waivers. It is the family choice which waiver they feel the child would be the most appropriate, providing the child meets established criteria.
- The Autism Specialist should initiate the first contact to the appropriate waiver the child will be transitioning to when they exit the Autism Waiver.
- After releases of information have been signed the Autism Specialist should share and coordinate the transfer of all relevant documentation/information to the appropriate waiver being utilized for a successful transition.

- The Autism Specialist should be in attendance with the TCM for either the SED or MRDD waiver completes their assessment if family permits.
- The HCBS/SED or HCBS/MRDD should complete the ES 3160 to send to the SRS EES worker for opening a waiver case.
- The Autism Specialist will send the ES 3161 to the SRS EES worker to close the HCBS Autism waiver case.

## **H-1 Complaints**

As an advocate for the person receiving services, the Autism Specialist should help resolve any complaints the child or family may have. If the Autism Specialist is not able to alleviate the problem or the complaint is with the Autism Specialist agency, or the person's Autism Specialist, they should be directed to do the following:

- a. If the complaint is with the person's Autism Specialist they should try to resolve the problem at that level. If that is not possible, the child or family needs to discuss the matter with the Autism Specialist supervisor, or the Director of the Autism Specialist agency (if applicable).
- b. If the child or family feels the complaint needs further resolution, they may want to contact CSS's Quality Management Specialist (QMS) in their region. To find out who your QMS go to: <http://www.srs.ks.gov/agency/css/Pages/CSSServices.aspx>. The child or family also has the option of filing a complaint with the grievance unit of the fiscal agent. When a complaint is made, the fiscal agent logs and tracks complaints and if a provider has three complaints submitted against them, an investigation is then initiated.
- d. Complaints regarding physical, mental or emotional abuse or neglect or sexual abuse should be referred to Child Protective Services, K.S.A. 38-2201.

## **H-2 Consumer Grievance Unit**

The Medical Assistance Customer Service Center (MACSC) at the fiscal agent is open to any complaint, concern, or grievance a consumer has. MACSC staff log and track all contacts, whether received by phone, email or letter. Those grievances which require extensive research or quality of care issues are referred to the Quality Assurance Team (QAT) for resolution.

Grievances handled with in MACSC are normally resolved within 5 working days. Those grievances which are referred to QAT are resolved within 30 days. QAT must have the KHPA program manager's approval to extend the resolution time of a grievance beyond 30 days. QAT must also contact the grievant within 4 working days of receipt of a grievance.

QAT trends grievances on a monthly basis. Criterion for further research is based on number of grievances per provider in a specific time frame.

Functional Eligibility Specialist and/or Autism Specialist inform the child/family about the Complaint and Grievance process. Child/family is educated that lodging a complaint and/or grievance is not a pre-requisite or substitutes for a Fair Hearing and is a separate activity from a Fair Hearing.

## **H-3 Request for Fair Hearing**

When a person receiving Autism Waiver services does not agree with the decision of the

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Autism Specialist, or Autism Waiver Program Manager, they may appeal the decision at the state level if they cannot work the issue(s) out with an agency representative. Persons receiving services have a right to a Fair Hearing before the State of Kansas Department of Administration's Office of Administrative Hearings if their request is received in writing within 30 days of receiving the Notice of Action (NOA) they are disputing according to K.A.R. 30-7-65. The Autism Specialist or Autism Waiver Program Manager should explain the Fair Hearing procedure and supply the necessary forms to the individual.

The person may choose to have legal counsel or other representation at the Fair Hearing. If a request for a Fair Hearing is received prior to the effective date of the NOA, assistance may continue at the current level pending a decision; however, any overpayment from a continuation may be recovered if the decision is not reversed. If the child/family is then dissatisfied with the Fair Hearing decision, they may request a review of the decision by the State Appeals Committee.

a. Fair Hearing Procedure

- i. The individual receiving Autism Waiver services must submit their request for Fair Hearing to the community agency and to the Office of Administrative Hearings (OAH). The request must be in writing but no specific form is required.
- ii. The OAH will send the request for Fair Hearing from the Autism Waiver family to the Autism Waiver Program Manager.
- iii. The Autism Waiver Program Manager will send the request for Fair Hearing to the Autism Specialist. The agency director will prepare an agency summary per K.A.R. 30-7-75. If the agency director needs assistance in preparing the summary, the Autism Waiver Program Manager will provide assistance.
- iv. If the Autism Waiver Program Manager prefers to prepare the agency summary, they may do so.
- v. All parties involved in the request for Fair Hearing are responsible for meeting the time frames set by the OAH. Failure to comply with these time frames may result in a reversal of the agency decision.
- vi. If the agency director prepares the summary, they should give the summary to the Autism Waiver Program Manager to submit to the OAH within the given time frame.
- vii. Once the Fair Hearing is scheduled, the OAH will notify the Autism Waiver Program Manager of the date, time and location. It is the responsibility of the Autism Waiver Program Manager to notify all witnesses. Only three different locations can be connected by telephone

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for the appeal hearing. The appeal can also be held in-person at the Topeka OAH office, or by means of a record review.

- viii. If the individual receiving services has an attorney present at the hearing, it is recommended that SRS and/or the community agency be represented by counsel. If the individual does not have an attorney present at the hearing, the Autism Waiver Program Manager or agency director may have an attorney present at their discretion.

b. Preparing for the Fair Hearing

1. The Autism Waiver Program Manager attends as a representative of SRS. The community agency is responsible for justifying their actions to the Hearing Officer.
2. The Autism Waiver Program Manager prepares the SRS opening statement which is to include the following:
  - i. What is/are the issue(s):
  - ii. Identify the program(s) involved.
  - iii. Include the source of authority for the agency's actions (e.g., manual reference, regulations, statutes, etc.).
3. It is the responsibility of the Direct Services Provider to gather the facts that Support their actions.
  - i. Documents (e.g., NOAs, case notes, IBP/POC, ES forms, correspondence, etc.).
  - ii. Identify the witnesses and request they be subpoenaed. Be sure to contact them prior to when they will be served with the subpoena.
4. Subpoenas
  - i. Submit the request to the OAH.
  - ii. Have the subpoena served and complete the affidavit.
  - iii. The following are examples of when a subpoena should be requested:
    - a. SRS eligibility worker and/or their supervisor – Regulations regarding HCBS budgeting and copies of KAECSES screen showing the financial eligibility determination for Autism Waiver services. Copies of pertinent notices, any ES-3160s or ES3161s regarding the situation, and the eligibility case file.
    - b. Community agency representative – HCBS eligibility criteria and scoring of needs and any other sections pertinent to the appeal

situation. Copies of notices and the case file including the updated case notes.

5. Meet with witnesses and prepare them for their presentation at the Fair Hearing.

#### **H-4 Case Closure after Fair Hearing**

When an issue relating to eligibility has gone through the Fair Hearing process and the agency's action is upheld (i.e., ineligibility for services), the case must be closed immediately upon notification of the Hearing Officer's findings.

Office of Administrative Hearings (OAH) Fair Hearing Process, the Office of Administrative Hearings conducts fair and impartial hearings for citizens and other affected parties when they contest the actions of the state agencies determining their legal rights.

1. Request for Fair Hearing- must be made in writing and received by OAH within 30 days of the date of the agency's notice of action; appellant can use OAH form or just provide a written statement of what they are appealing.
2. Pre-Conference Hearing- doesn't always take place; it depends on the circumstances.
3. Hearing-Can be in person, by conference call, or on the review of records.
4. Initial Order of Presiding Officer- If no one requests a review by the State Appeals Committee, then the order becomes final and binding on the 30<sup>th</sup> day following the order being served. (OAH can affirm, remand, or reverse.)
5. Request for Review by State Appeals committee-Due 15 days from date of order. Appellant (or whoever is requesting the review) is responsible for having a transcript of the hearing prepared and paying for it.
6. Order of State Appeals Committee-Becomes final when signed by the Secretary. Appellant has the right to file a petition for judicial review with the appropriate District Court (county in which the order takes effect) within 30 days of the final order. If this is done, they must serve a copy of the petition to the Secretary of SRS and should notify OAH of the appeal of the final order.
7. Petition for Reconsiderations-(rarely used it since goes back to the Secretary who signed and finalized the Order of the State Appeals Committee.) Must be filed

*Appeals & Dispute Resolution*

within 15 days to the agency head. Agency head has 20 days to render a written order. This petition is not a prerequisite for seeking judicial review of the agency head's final order. If reconsideration has not been requested and is not a prerequisite for seeking judicial review, a petition for judicial review of a final order shall be filed within 30 days after service of the order.

*Things to remember when involved in an OAH Appeal:*

1. All information regarding an appeal is subject to strict confidentiality standards.
2. All final orders served by mail get 3 days added to time limits.
3. Documentation is extremely important to support any actions that have been taken.
4. All correspondence or contact regarding the appeal should be directly solely to the Autism Waiver Program Manager or Agency Director.
5. An SRS Attorney may be involved depending on the type and complexity of the appeal.

*OAH Contact Information:*

Kansas Department of Administration Office of Administrative Hearings

1020 S. Kansas Ave., Topeka, KS 66612-1327

Telephone: (785) 296-2433

Fax: (785) 296-4848

E-mail: [oah@da.state.ks.us](mailto:oah@da.state.ks.us)

Web page: <http://da.state.ks.us/hearings>

CSS also has a web page with information on Fair Hearings at:

<http://www.srskansas.org/hcp/css/appeals.html>

**I Quality Assurance Tool**



# KANSAS

## DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



### Disability & Behavioral Health Services Community Supports & Services HCBS Autism Quality Review Instrument

Child's Last Name:	First Name:	Date of Review:	Beneficiary ID#:
SRS Region:	Autism Specialist:	Waiver Services Utilized:	
Who was present at the review (name/role):	QA Staff Name:	A QA Follow-up Form was completed? Yes or No:	

**Instructions: SRS staff will interview family members or guardians, whichever is most appropriate in the individual circumstance, when the review instrument calls for a “family interview”. During each review SRS staff will have seen the child in the home environment at a minimum, and observed HCBS service provision when at all possible. SRS staff will carry a card with the rating scale on it to provide the family or staff persons being interviewed.**

**Rating Scale: 1 = Strongly Disagree / 2 = Disagree / 3 = Undecided / 4 = Agree / 5 = Strongly Agree / 6 = Not Applicable**

	Source		Issue	Standard	Rating	Interpretive Guideline / SRS Staff Instructions
1	Family Interview	1c	LOC	The Level of Care (waiver eligibility determination process) was conducted in person with the family.		Ask the family “Was one of the parents/guardian present for the eligibility determination assessment?” SRS staff are to describe the eligibility determination process, when necessary, to ensure understanding by the family.
2	Family Interview	2a	Support Planning	The service plan adequately addresses the child’s needs.		Ask the family “Does the Individualized Behavioral Program / Plan of Care address your child’s needs?”
3	Family Interview	2b	Support Planning	Family members were involved in the development of the service plan.		Ask the family “Were you involved in the development of the Individualized Behavioral Program / Plan of Care?”

4	Family Interview	2a	Support Planning	Service plan reflects family priorities.		Ask the family “Does the Individualized Behavioral Program / Plan of Care reflect your family’s priorities?”
5	Observation / Family Interview / Documentation Review	2d 3b	Support Planning	Services are delivered in accordance with the service plan including the type and scope, amount, and frequency specified in the service plan.		At the child’s home: observe services being delivered and review Individualized Behavioral Program / Plan of Care and related documentation to ensure services are implemented as designed with regard to type (IIS, Autism Specialist, etc), scope (within identified design) and frequency (how long and how often). <i>Note: SRS staff will not complete the QA follow-up form and send to the provider when this question has a negative response due to lack of provider capacity. E.g there is not a provider to provide the service.</i>
6	Family Interview	2d	Service Delivery	The family knows who to contact if there are service delivery concerns regarding their child’s services.		Ask the family “Do you know whom to contact if you have service delivery concerns about your child’s services?”
7	Family Interview	2a	Health & Safety	The child is safe when receiving HCBS waiver services.		Ask the family “Is your child safe when receiving HCBS Autism Waiver services?”
8	Family Interview	2Eb	Participant Choice	The family was given choice of service providers.		Ask the family “Did you choose the people that provide services to your child and understand you can change people/providers at any time?”
9	Family Interview	2Eb	Participant Choice	The family chose their Autism Specialist.		Ask the family “Did you choose the autism specialist?” Ensure the family chose from a list of options.
10	Family Interview	2Eb	Participant Choice	The family is aware of all the available services available through the Autism Waiver		Ask the family “Did the Autism Specialist inform you about all of the services available to your child through the Autism Waiver”? Determine if the family is aware of the various services: Autism Specialist; Intensive Individual Support; Respite; Parent Support; and Family Adjustment

						Counseling.
11	Family Interview	2a	Service Delivery	There is an adequate amount of team meetings conducted.		Ask the family “Are an adequate amount of team meetings conducted?” Determine if there have been times when team meetings were requested/needed but did not occur.
12	Family Interview	2a	Service Delivery	The Autism Specialist is available for consultation for the family.		Ask the family “Is the Autism Specialist available for consultation?”
13	Family Interview	4	Health & Safety	The family knows whom to contact if they suspect abuse, neglect and/or exploitation?		Ask the family “Do you know whom to contact if you suspect abuse, neglect and/or exploitation?” The family should be able to describe how to contact SRS child protective services; as well as the employer of the suspected perpetrator.
14	Family Interview	2a 2d	Service Delivery  ADD Question for each service	The family is satisfied with the direct support waiver services.		Ask the family “Are you satisfied with the persons who work directly (IIS, Respite, etc.) with your child providing HCBS Autism Waiver services?” <i>Note: Ensure the family knows this question is not inclusive of the Autism Specialist as that service is addressed in next question.</i>
15	Family Interview	2a 2d	Service Delivery	The family is satisfied with the service provided by the Autism specialist.		Ask the family “Are you satisfied with the services provided by the Autism Specialist?”
16	Staff Interview	2e	Service Delivery	There is an adequate amount of team meetings conducted.		Ask the staff “Are an adequate amount of team meetings conducted?” Determine if there have been times when team meetings were requested/needed but did not occur. <i>(If a direct support staff is not present during the visit, the SRS staff will contact them by phone)</i>
17	Staff Interview	2a 2d	Service Delivery	Is the Autism Specialist available for consultation for the direct support staff.		Ask the staff “Is the Autism Specialist available for consultation when necessary?”
18	Staff Interview	2a 4	Health & Safety	Support staff know whom to contact if he/she suspects abuse,		Ask the staff “Do you know whom to contact if you suspect abuse, neglect

				neglect and/or exploitation.		and/or exploitation?” The staff should be able to describe how to contact SRS child protective services; as well as the employer of the suspected perpetrator.
19	Documentation Review	1b	LOC	A Level of Care is completed at least annually		An assessment was finalized and completed within 365 days of the previous one. (Vineland) (Autism Specialist)
20	Documentation Review	1c	LOC	The identified Level of Care (waiver eligibility determination process and instrument) was completed as designed.		A Vineland assessment is complete.
21	Documentation Review	2c	Support Planning	The service plan was revised at least annually or when warranted by changes in the child’s needs.		The Individualized Behavioral Program / Plan of Care has been updated/revised and signed within the last 365 days. (Autism Specialist and family home)
22	Documentation Review	2a	Support Planning	Provider documentation reflects service plan implementation.		Service provider documentation reflects implementation of goals and strategies identified in the Individualized Behavioral Program / Plan of Care. (Family Home)
23	Documentation Review	2Ea	Participant Choice	An HCBS choice form has been signed by the family.		The form is signed by the family member and is a part of the person’s record. <i>Note: This is the form where they choose between HCBS services and institutional services.</i> (Autism Specialist)
24	Documentation Review	1c	Qualified Providers	Persons conducting the Level of Care evaluation have the appropriate credentials.		At a minimum a Masters degree in Psychology, Social Work, with one of the fields of study indicated for the test that included training (through coursework and supervised practical experience) in the administration and interpretation of clinical instruments; or licensure to practice psychology independently, or a member of the National Association of School Psychologists; or user has completed a doctoral degree.
25	Documentation Review	3a 3b	Qualified Providers	Autism Specialist has required credentials.		Master’s degree, preferably in human services or education or a board certified

					behavior analyst (BCBA) and documentation of 2,000 hours of supervised experience working with a child with autism spectrum disorder (ASD); successfully pass Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aid Registry, and Motor Vehicle screens. * Exception: A BCBA can request that the program manager waive 1,000 hours of the required experience if documentation indicating the hours of supervised experience working with a child with ASD..
26	Documentation Review	3a 3b	Qualified Providers	Intensive Individual Support provider has required credentials.	Bachelor's degree, preferably in human services or education, or 60 college credit hours and documentation of 1,000 hours experience working with a child with ASD. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must work under the direction of the autism specialist.
27	Documentation Review	3a 3b	Qualified Providers	Respite Care provider has required credentials.	High school diploma or equivalent; 18 years of age or older; must reside outside of child's home. Respite care may not be provided by a parent of the child. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must work under the direction of the autism specialist.
28	Documentation Review	3a 3b	Qualified Providers	Parent Support provider has required credentials.	High school diploma or equivalent; 21 years of age or older; must have three years of direct care experience with a child with ASD or be the parent of a child three years of age or older with ASD. Must successfully pass KBI, APS, CPS, Nurse

						Aid Registry, and Motor Vehicle screens. Must work under the direction of the autism specialist.
29	Documentation Review	3a	Qualified Providers	Family Adjustment Counseling provider has required credentials.		Must hold a current license to practice as a licensed mental health professional (LMHP) by the State of Kansas Behavioral Sciences Regulatory Board. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must maintain an ongoing collaborative relationship with the autism specialist beginning at the time of referral.
30	Documentation Review	1a	Level of Care	An initial level of care was completed for all applicants for whom there is reasonable indication that services may be needed in the future.		Check to ensure an initial Vineland was completed for the child when they were approved for services. (Autism Specialist file)
31	Documentation Review	2b	Support Planning	The service plan is developed in accordance with the state approved policies and procedure.		The Individualized Behavioral Program / Plan of Care is in compliance with section E-1 of the Autism Waiver Manual. (Autism Specialist and family home)
32	Documentation Review	3c	Qualified Providers	Provider training is conducted in accordance with state requirements.		Autism Waiver provider training has been initiated or is in progress (6 months to complete) or has been completed. Note: Check the list of names provided by the KU's Kansas Center for Autism Research and Training (KCART).

*NOA Instructions*

This form is to be filled out by the Functional Eligibility Specialist and/or Autism Specialist. This form is to be received by the child/family of HCBS services and any effected providers.

This form serves as a notice of changes in HCBS Autism services. Please complete all sections of this form.

**Definitions:**

**Date of Notice** – The date this form is being completed.

**To** – The name of the child/family receiving the services.

**From** – The Functional Eligibility Specialist and/or Autism Specialist, name, address and phone number.

**Medicaid ID** – Child’s Medicaid number, (Functional Eligibility Specialist may not have a Medicaid number when the initial assessment is completed and a NOA needs to be sent to notified family in writing the results of the functional determination.

**Service & Procedure Code** – List the name of the service and the corresponding procedure code.

**Dates of Services** – The date the services began until the anticipated date that the services end. If this is a notice regarding the ending of services be sure and include the last date services will be provided.

**Comments, Messages or Explanation of Action** – Please fill in the date the change will become effective. You must state the reason why services are changing. For example:

- Individual Supports services hours are being reduced from 20 hours per week to 15 hours per week per parent’s request.
- You continue to meet functional eligibility criteria.
- Your HCBS Autism Waiver services will end July 15, due to Joe no longer meets the functional eligibility criteria, or Joe services will end on July 15 due to the 3 year service limitations for the Autism Waiver.
- Client obligation has changed, (give date of change and amount client obligation will change too).

**Regulatory Reference(s)** – Refer to policy & procedure manual, or if applicable, the KEESM manual.

**Cc:** - Copy of the NOA will be kept in the child’s case file. Effected providers of service should also receive a copy of the NOA if the change pertains to them.

**Functional Eligibility Specialist and/or Autism Specialist** – Name of Functional Eligibility Specialist who makes the functional determination and the Autism Specialist on the most recent Plan of Care.

**Home and Community –Based Services for the  
Autism Waiver  
NOTICE OF ACTION**

**Date of Notice:**

<p><b>TO:</b></p>  <p><b>ATTENTION:</b></p>	<p><b>FROM</b></p> <p><b>Agency:</b> <b>Address:</b> <b>Agency Phone</b></p>
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**Medicaid #**

SERVICE & PROCEDURE CODE (S)	PROVIDER NAME & NUMBER	DATES OF SERVICES	
		FROM	THRU

**COMMENTS, MESSAGE OR EXPLANATION OF ACTION**

Feel free to contact me if you have questions. \_\_\_\_\_ or \_\_\_\_\_

\* Important information regarding your rights and responsibilities, including information about your appeal rights, Is on the back of this form. Appeal requests must be received by the Office of Administrative Hearings, 1020 S. Kansas Topeka, KS 66612-1327 within 30 days of the date of this Notice of Action. Three (3) days will be added for mailing time. No special form is required, but the request must be in writing describing the decision appealed and the reason for the appeal.

Policy Reference:

Cc: file, Service Provider’s

Functional Eligibility Specialist and/or Autism Specialist \_\_\_\_\_

## Consumer Rights & Responsibilities

**Right to Request a Fair hearing (appeal a decision):** If you have any questions about the action taken or if you want more information Considered before the planned action is taken, discuss these matters with an agency representative. If you remain dissatisfied, you have the Right to request a fair hearing through the State of Kansas' Department of Administration's Office of Administrative Hearings (OAH). Your request must be received, in writing, within 30 days of receiving this notice of action (an additional three days is given for mailing time) to the following address:

Office of Administrative Hearings  
1020 S. Kansas Avenue  
Topeka, KS 66612-1327  
Telephone: 785-296-2433  
Fax: 785-296-4848

The agency that sent you this Notice of Action (NOA) will explain the hearing process and supply you with the necessary forms upon your request. You may also contact your local SRS office for this information. You may have legal counsel or other representation at the hearing. If a request for a fair hearing is received prior to the effective date of action, assistance may continue at the current level pending a decision; however, any overpayment from a continuation may be recovered if the decision is not in your favor. If you are dissatisfied with a fair hearing decision, you may request a review of the decision by the state appeals committee. For further information on the fair hearing process, see the following web site at: <http://www.srskansas.org/hcp/css/appeals.html>.

**Civil Rights:** No person shall, on the grounds of race, color, national origin, age disability, religion, or sex be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity of the Department of Social and Rehabilitation services. If you feel that you have been discriminated against on the above grounds, you may make a complaint in writing to the Department of Social and Rehabilitation Services or the United States Department of Health and Human Services.

**Reporting to Autism Specialist:** You are required to report any change that will affect the amount, location, or the date of payment for any of your services. For example, if you plan to move, are admitted to the hospital, nursing facility, or will be away from home long enough for changes to occur in the reimbursement of your services, the case manager must be informed to ensure reimbursement is made appropriately and timely for your services.

**Reporting to Economic & Employment Services (EES) Specialist:** You are required to report any change in income, resources, or living arrangements to your Social and Rehabilitation Services Economic & Employment Services (EES) Specialist.

### **Your Rights and Responsibilities as a Medicaid Applicant/Recipient:**

1. You have the right to have your eligibility for Medicaid services determined within 45 days.
2. You have the right to services which are provided to persons in your category of eligibility in accordance with the Medicaid state plan, based on the availability of services and fiscal limitations.
3. You have the right to a fair hearing if you are dissatisfied with any adverse decision made regarding your services.
4. You have the right to receive equal treatment as compared to other applicants/recipients who are in similar situations.
5. You have the responsibility to report all changes in circumstances to your case manager and local SRS office (including income, hospitalization, living arrangements, etc.,) which may affect your Medicaid application, eligibility, and/or subsequent services.
6. You have the responsibility to cooperate in any current and subsequent efforts to establish your Medicaid and related program eligibility.
7. You have the responsibility to pay your share of services costs, if applicable, in accordance with your assigned Medicaid client obligation.
8. You have the responsibility to participate in any reviews or audits of your level of care and/or services by the Medicaid fiscal agent, SRS personnel, or your case management agency.

**Servicios Basados en el Hogar y la Comunidad Exención por Autismo/  
Home and Community-Based Services for the Autism Waiver  
AVISO DE ACCIÓN/NOTICE OF ACTION**

**Fecha de Aviso/Date of Notice:**

**A/TO:**

**DE/FROM**

**ATENCIÓN/ATTENTION:**

**Agencia/Agency:**

**Domicilio/Address:**

**Teléfono de la Agencia/Agency Telephone**

**Medicaid N°/Medicaid #**

**CODIGO(S) DE SERVICIO Y  
PROCEDIMIENTO/  
SERVICE & PROCEDURE  
CODE(S)**

**NOMBRE Y NUMERO DEL  
PROVEEDOR/PROVIDER  
NAME & NUMBER**

**FECHAS DE LOS SERVICIOS/  
DATES OF SERVICES**

**DESDE/FROM    HASTA/THROUGH**

CODIGO(S) DE SERVICIO Y PROCEDIMIENTO/ SERVICE & PROCEDURE CODE(S)	NOMBRE Y NUMERO DEL PROVEEDOR/PROVIDER NAME & NUMBER	FECHAS DE LOS SERVICIOS/ DATES OF SERVICES	
		DESDE/FROM	HASTA/THROUGH

**COMENTARIOS, MENSAJE O EXPLICACIÓN DE LA ACCIÓN/COMMENTS, MESSAGE OR EXPLANATION OF ACTION**

Siéntase libre de comunicarse conmigo si usted tiene preguntas.

\* En el dorso de este formulario se incluye información importante con respecto a sus derechos y responsabilidades, incluyendo información acerca de su derecho a apelar. Las solicitudes de apelación deben ser recibidas por la Oficina de Audiencias Administrativas, 1020 S. Kansas, Topeka, Kansas 66612-1327 dentro de un plazo de 30 días a partir de la fecha de este Aviso de Acción. Se agregarán tres (3) días para el plazo de envío. No se requiere un formulario especial, sin embargo la solicitud debe ser realizada por escrito describiendo la decisión apelada y el motivo de la apelación.

Referencia de la Política/Policy Reference:

Cc: archivo, Proveedor de Servicio/Cc: file, Service Provider's

Especialista en Elegibilidad Funcional y/o Especialista en Autismo  
Functional Eligibility Specialist and/or Autism Specialist \_\_\_\_\_

## **Derechos y Responsabilidades del Consumidor** **Consumer Rights & Responsibilities - Spanish**

**Derecho a Solicitar una Audiencia Justa (apelar una decisión):** Si usted tiene alguna pregunta acerca de la acción tomada o si usted desea que se considere más información antes de que sea tomada la acción planificada, discuta estos temas con un representante de la agencia. Si usted sigue estando disconforme, usted tiene el Derecho a solicitar una audiencia justa a través de la Oficina de Audiencias Administrativas (OAH por sus siglas en inglés) del Departamento de Administración del Estado de Kansas. Su solicitud debe ser recibida, por escrito, dentro de un plazo de 30 días a partir de la recepción de este aviso de acción (se proporcionan tres días adicionales para el tiempo de envío) en el siguiente domicilio:

Office of Administrative Hearings  
1020 S. Kansas Avenue  
Topeka, KS 66612-1327  
Número de Teléfono: 785-296-2433  
Fax: 785-296-4848

La agencia que le envió este Aviso de Acción (NOA por sus siglas en inglés) le explicará el proceso de audiencia y le proporcionará los formularios necesarios cuando usted lo solicite. Usted también puede comunicarse con su oficina local de Servicios Sociales y de Rehabilitación (SRS por sus siglas en inglés) para obtener esta información. Usted puede tener asesoramiento legal u otra representación durante la audiencia. Si una solicitud para una audiencia justa es recibida antes de la fecha efectiva de acción, la asistencia podría continuar en el nivel actual quedando pendiente una decisión; sin embargo, cualquier sobrepago realizado durante una continuación podría ser recuperado si la decisión no resulta a su favor. Si usted está disconforme con una decisión de la audiencia justa, usted podría solicitar una revisión de la decisión por parte del comité de apelaciones del estado. Para más información acerca del proceso de audiencia justa, consulte el siguiente sitio Web en:

<http://www.srskansas.org/hcp/css/appeals.html>.

**Derechos Civiles:** Ninguna persona debe, por razones de raza, color, nacionalidad, edad, discapacidad, religión, o sexo, ser excluida de participar en, ser denegada los beneficios de, o estar sujeta a discriminación bajo cualquier programa o actividad del Departamento de Servicios Sociales y de Rehabilitación. Si usted considera que ha sido discriminado por las razones mencionadas anteriormente usted puede presentar una queja por escrito al Departamento de Servicios Sociales y de Rehabilitación o al Departamento de Salud y Servicios Humanos de los Estados Unidos.

**Informe al Especialista en Autismo:** Se le requiere a usted que informe cualquier cambio que pudiera afectar el monto, la ubicación, o la fecha de pago de cualquier de sus servicios. Por ejemplo, si usted planifica mudarse, es admitido en un hospital, institución de enfermería, o estará lejos de su hogar el tiempo suficiente como para que ocurran cambios en el reembolso de sus servicios, el administrador del caso debe ser informado para asegurar que el reembolso sea realizado en forma apropiada y puntual para sus servicios.

**Informe al Especialista en Servicios Económicos y Empleo (EES, por sus siglas en inglés)** Se le requiere a usted que informe cualquier cambio en sus ingresos, recursos, o arreglos de vivienda a su Especialista en Servicios Económicos y Empleo (EES) de los Servicios Sociales y de Rehabilitación

### **Sus derechos y Responsabilidades como Solicitante/Receptor de Medicaid:**

Usted tiene el derecho a que su elegibilidad para servicios Medicaid sea determinada dentro de un plazo de 45 días.

Usted tiene el derecho a servicios que son proporcionados a personas en su categoría de elegibilidad de acuerdo con el plan estatal Medicaid, en base a la disponibilidad de servicios y limitaciones fiscales.

Usted tiene el derecho a una audiencia justa si usted está disconforme con cualquier decisión adversa tomada con respecto a sus servicios.

Usted tiene el derecho a recibir igual tratamiento que los otros solicitantes/receptores que se encuentren en situaciones similares.

Usted tiene la responsabilidad de informar cualquier cambio en sus circunstancias a su administrador del caso y oficina local del SRS (incluyendo ingresos, hospitalización, arreglos de vivienda, etc.) que pudieran afectar su solicitud Medicaid, elegibilidad, y/o posteriores servicios.

Usted tiene la responsabilidad de cooperar con cualquier esfuerzo actual y posterior para establecer su elegibilidad para Medicaid y para el programa relacionado.

Usted tiene la responsabilidad de pagar su parte de los costos de servicio, si fuera aplicable, de acuerdo con su obligación de cliente Medicaid asignada.

Usted tiene la responsabilidad de participar en cualquier revisión o auditoria de su nivel de cuidado y/o servicios por el agente fiscal de Medicaid, personal del SRS, o su agencia de administración del caso.

CHOICE FORM  
HOME AND COMMUNITY-BASED SERVICES  
FOR CHILDREN WITH AN AUTISM SPECTRUM DISORDER (ASD)

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Medicaid Number

The results of the assessment of my child's functional needs indicate that they qualify for Home Community Based Services (HCBS) Autism Waiver Services. I have been informed that my child is functionally eligible to receive services and may opt to remain in the community and receive services through the HCBS Autism as an alternative to an inpatient psychiatric facility for individuals under 21 years of age.

READ REVERSE SIDE OF THIS FORM BEFORE PROCEEDING.

My choice is to: (check one)

\_\_\_\_\_ Keep my child at home in the community with support from the HCBS Autism Waiver and request an Autism Specialist work with me to develop an Individualized Behavioral Program.

\_\_\_\_\_ Pursue an inpatient psychiatric facility for individuals under 21 years of age.

\_\_\_\_\_ Refuse Services

SIGNATURES:

DATES:

\_\_\_\_\_  
Parent / Legal Guardian

\_\_\_\_\_

\_\_\_\_\_  
Functional Eligibility Specialist

\_\_\_\_\_

*(This form needs to be completed at the time the Child's Functional Eligibility determination and re-determination is made)*

## Consumer Rights & Responsibilities

**Right to Request a Fair hearing (appeal a decision):** If you have any questions about the action taken or if you want more information Considered before the planned action is taken, discuss these matters with an agency representative. If you remain dissatisfied, you have the Right to request a fair hearing through the State of Kansas' Department of Administration's Office of Administrative Hearings (OAH). Your request must be received, in writing, within 30 days of receiving this notice of action (an additional three days is given for mailing time) to the following address:

Office of Administrative Hearings  
1020 S. Kansas Avenue  
Topeka, KS 66612-1327  
Telephone: 785-296-2433  
Fax: 785-296-4848

The agency that sent you this Notice of Action (NOA) will explain the hearing process and supply you with the necessary forms upon your request. You may also contact your local SRS office for this information. You may have legal counsel or other representation at the hearing. If a request for a fair hearing is received prior to the effective date of action, assistance may continue at the current level pending a decision; however, any overpayment from a continuation may be recovered if the decision is not in your favor. If you are dissatisfied with a fair hearing decision, you may request a review of the decision by the state appeals committee. For further information on the fair hearing process, see the following web site at: <http://www.srskansas.org/hcp/css/appeals.html>.

**Civil Rights:** No person shall, on the grounds of race, color, national origin, age disability, religion, or sex be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity of the Department of Social and Rehabilitation services. If you feel that you have been discriminated against on the above grounds, you may make a complaint in writing to the Department of Social and Rehabilitation Services or the United States Department of Health and Human Services.

**Reporting to Autism Specialist:** You are required to report any change that will affect the amount, location, or the date of payment for any of your services. For example, if you plan to move, are admitted to the hospital, nursing facility, or will be away from home long enough for changes to occur in the reimbursement of your services, the case manager must be informed to ensure reimbursement is made appropriately and timely for your services.

**Reporting to Economic & Employment Services (EES) Specialist:** You are required to report any change in income, resources, or living arrangements to your Social and Rehabilitation Services Economic & Employment Services (EES) Specialist.

**Your Rights and Responsibilities as a Medicaid Applicant/Recipient:**

1. You have the right to have your eligibility for Medicaid services determined within 45 days.
2. You have the right to services which are provided to persons in your category of eligibility in accordance with the Medicaid state plan, based on the availability of services and fiscal limitations.
3. You have the right to a fair hearing if you are dissatisfied with any adverse decision made regarding your services.
4. You have the right to receive equal treatment as compared to other applicants/recipients who are in similar situations.
5. You have the responsibility to report all changes in circumstances to your case manager and local SRS office (including income, hospitalization, living arrangements, etc.,) which may affect your Medicaid application, eligibility, and/or subsequent services.
6. You have the responsibility to cooperate in any current and subsequent efforts to establish your Medicaid and related program eligibility.
7. You have the responsibility to pay your share of services costs, if applicable, in accordance with your assigned Medicaid client obligation.
8. You have the responsibility to participate in any reviews or audits of your level of care and/or services by the Medicaid fiscal agent, SRS personnel or your case management agency.



**HCBS/Autism Waiver  
AUTHORIZATION FOR EXCHANGE OF INFORMATION**

Name: \_\_\_\_\_ SS #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Telephone H#: \_\_\_\_\_ Wk#: \_\_\_\_\_  
 Street Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize the two agencies and/or persons listed below to exchange information regarding my case.

Agency &/or Person \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax \_\_\_\_\_ E-mail: \_\_\_\_\_

Agency &/or Person \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax \_\_\_\_\_ E-mail: \_\_\_\_\_

All types of information listed below will be used unless otherwise noted by initialing below:

- |   |   |
|---|---|
| <input type="checkbox"/> All Records/Information                  | <input type="checkbox"/> Psychological Evaluation(s), IQ Scores & Tests |
| <input type="checkbox"/> Dental                                   | <input type="checkbox"/> School Records                                 |
| <input type="checkbox"/> Medical Records, including Diagnosis     | <input type="checkbox"/> Social History                                 |
| <input type="checkbox"/> Program Plans, Evaluations & Assessments | <input type="checkbox"/> Other: _____                                   |

This information may be released in the following format(s):  Audio/Visual  Electronic  Verbal  
 Written  Other: \_\_\_\_\_

I understand the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

I understand that this authorization may be revoked by the person served and/or their guardian at any time except to the extent the action has already taken place. I understand that if I revoke this authorization I must do in writing and present my written revocation to the information management department. Unless otherwise revoked, this authorization will expire on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 (Not to exceed one year from date of signature).

I have read the above Authorization for Release of Information / Permission to Obtain and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this release.

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Signature of Person Served: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Signature of Authorized Representative: \_\_\_\_\_

Representative: \_\_\_\_\_  
 (\*\*Please complete the following section if signed by a Parent, Guardian, or Authorized Representative)

Printed Name of Parent/Guardian or Authorized Representative: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to the Person: \_\_\_\_\_

## Service Provider Selection Summary

I have chosen the following Service Providers:

**Consultative Clinical &  
Therapeutic Services:**

**(Autism Specialist)** \_\_\_\_\_  
Name Date

**Intensive Individual Support:** \_\_\_\_\_  
Name Date

\_\_\_\_\_  
Name Date

\_\_\_\_\_  
Name Date

**Respite Services:**

\_\_\_\_\_  
Name Date

\_\_\_\_\_  
Name Date

**Parent Support & Training:**

\_\_\_\_\_  
Name Date

\_\_\_\_\_  
Name Date

**Family Adjustment**

**Counseling:**

\_\_\_\_\_  
Name Date

I understand that I have the option to change service providers at any time, without jeopardizing any public funding source.

This does not guarantee funding for chosen services.

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

*(This form is to be maintained in the child's original file, and updated when providers change or at a minimum annually)*

*Autism Specialist provides and assists family in completing form)*

*Complete list of approved providers can be found at:*

***<http://www.srs.ks.gov/agency/css/Pages/Autismwaiver/AutismWaiver.aspx>***

*New Providers may enroll at anytime.*

HCBS Autism Waiver  
Individualized Behavioral Program/Plan of Care

AW-004

Section I - Demographics

1. Date of IBP/POC \_\_\_\_\_

HCP/CSS Office Use Only  
Exception Date Rec'd: \_\_\_\_\_  
Initials: \_\_\_\_\_

Initial IBP \_\_\_\_\_ Revision \_\_\_\_\_

Year 2 \_\_\_\_\_ Year 3 \_\_\_\_\_ Exception \_\_\_\_\_

2. Child's Information

Name of Child \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender (circle one): M F

3. Parent / Legal Guardian Information

Name of Parent or Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone number: \_\_\_\_\_

\_\_\_\_ Natural / Adopted Parents \_\_\_\_ Foster Parents \_\_\_\_ Guardian \_\_\_\_ Child is in SRS Custody

4. Autism Specialist Information Provider No: \_\_\_\_\_

Name of Autism Specialist Provider: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Work Fax Number: \_\_\_\_\_

Work Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Independent Provider \_\_\_\_\_ Agency Provider \_\_\_\_\_

\*\*\*\* Note: Complete section 5 if the Autism Specialist is employed by an agency.

5. Agency Information Agency No: \_\_\_\_\_

Name of Agency: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Work Fax Number: \_\_\_\_\_

Work Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Type of Provider (choose the one that best describes your agency)

\_\_\_\_ Developmental Disability \_\_\_\_ Mental Health \_\_\_\_ Child Welfare

6. Assessment Score & Diagnosis:

Date the Vineland II Adaptive Behavior Scales was completed \_\_\_\_\_

Mm/dd/yy

**VINELAND II ADAPTIVE BEHAVIOR SCALES**

**Adaptive Areas:**

Communication \_\_\_\_\_

Daily Living Skills \_\_\_\_\_

Socialization \_\_\_\_\_

Motor skills \_\_\_\_\_

**Maladaptive Areas:**

Internalizing \_\_\_\_\_

Externalizing \_\_\_\_\_

Total \_\_\_\_\_

**Diagnosis:**

\_\_\_\_\_

\_\_\_\_\_

\*\*Must have a total score or a score on any two elements of the Adaptive areas below the score of 70 or below **OR** a total score or a score on any two elements of the Adaptive area score 71-85 and the maladaptive score on the internal, external or total is 21-24.

**7. Criterion Reference Skilled Based Assessment**

Name the type of Criterion Reference Skill Based Assessment utilized.

\_\_\_\_\_

**8. Treatment options**

Which evidence-based method is currently being used, or is planned for use for the early intensive intervention?

**ABA** (e.g. pivotal response training) \_\_\_\_\_

**DTT** (Discrete Trial Training) \_\_\_\_\_

**TEACCH** (Treatment and Education of Autistic and Communication-Handicapped Children) \_\_\_\_\_

**RDI** (Relationship Development Intervention) \_\_\_\_\_

Other evidenced-based practice \_\_\_\_\_

**9. Classroom or Educational Setting**

Does your child receive any mandated services? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, provide name of school/service? \_\_\_\_\_

What grade are they in? \_\_\_\_\_

**10. Behavior Impact Rating Tool**

**Interviewer, say to parent:** "Parent, using the following rating scale, please rate how satisfied you are with the impact of your child's needs on your and your family's daily life. Please base your responses on your child's worst day".

Very Dissatisfied	Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Satisfied	Very Satisfied	N/A
1	2	3	4	5	6	



Questions	Rating
1. My ability to take my child out in the community (ex. Grocery store, park, doctor's office, etc.).	
2. The extent to which my child effectively follows the directions given:	
3. My level of exhaustion at the end of the day.	
4. How will I handle my child's problem behavior across settings?	
5. The ability to leave my child with other people (babysitter, family, etc.)	
6. The strategies I currently use to stop the problem behavior when it is occurring.	
7. The amount of time I have to do things for myself.	
8. My understanding of why my child is engaging in problem behavior.	
9. The preventative strategies I use to lower the likelihood of problem behavior.	
10. Each person on the team's interactions with my child (i.e. everyone is consistent).	
11. My family's participation in community activities. (Ex. Church, school events, etc).	
12. My child's ability to communicate his/her wants and needs	
13. My child's friendships or interactions with typical peers and/or siblings.	
14. Our family's ability to interact with friends at their or our house.	

Very Dissatisfied	Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Satisfied	Very Satisfied	N/A
1	2	3	4	5	6	



Questions	Rating
15. My child's progress with his or her current educational services.	
16. Our ability to balance our family's needs with my child's needs.	
17. The ability of my child's current school or child care to address his or her individual needs.	
18. The intensity of supervision my child needs.	
19. My child's ability to do things for him/herself (ex. self-help skills, such as hand washing, toileting, sleeping, eating, etc.).	
20. The frequency, severity, and/or intensity of my child's problem behavior.	
21. My other children's feelings about my child (i.e. siblings).	
22. My child's overall happiness and quality of life.	
23. Others' perceptions of my parenting and disciplinary skills.	
24. The extent to which the child's problem behavior affects the relationship between my significant other and me.	
25. My ability to access support from professionals and/or network with other parents in similar situations.	
26. My ability to cope with stress and other issues related to my child (i.e. emotional well being).	

*(modified from Behavior Impact Rating Tool 2007 ALT)*

Please list the number of the preceding items that correspond to your 5 highest priorities.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list the top 3 problem behaviors to address.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**11. Global Risk Rating Scales:** Consider the previous information and what you know about the child's entire behavioral repertoire. Use the rating scale below to indicate the child's overall risk levels.



Questions	Rating
1. The child's behavior is dangerous to others	
2. The child's behavior provides a health risk to self (i.e., head banging, self-biting, etc.).	
3. The child's behavior results in significant damage to property.	
4. The child's behavior is likely to become serious in the future if not addressed.	
5. The child's behavior is occurring at such a frequency or intensity that a caregiver's ability to effectively provide support is being compromised.	
6. The child's behavior results in the involvement of law enforcement	
7. The child's overall behavior puts them at risk of institutionalization or loss of a. current least restrictive environment, such as at home or at school.	

## Section II - Domains

Section II addresses the following 12 life domains;

1. Behavior
2. Communication: Expressive
3. Communication: Nonverbal
4. Communication: Receptive
5. Community Readiness Skills
6. Concept Formation Skills
7. Family Environment
8. Imitation and Attending
9. Leisure/Recreation/Play
10. Motor Skills
11. Self-Help Skills
12. Social Interactions

**Instructions:**

Each domain must be addressed, under each domain there are several sub-domains listed and at least one of those listed sub-domains must also be addressed. If there are more sub-domains to be included please use additional sheets as necessary. Additional sheets are included in the appendices.

Examples of how to complete the domains are in the Autism Policy & Procedure Manual in Section E (Assessment).

**A documented review of domains should be conducted by the Autism Specialist at least every 6 months.**

*Additional domain sheets are included in the Appendix 1.*

Child's Name:

**Sample**

Date:

<b>Domain: Identify which life domains will be addressed</b>		<b>Goal #</b>
<b>Summary (with family input):</b> A general overview of the child's performance within this domains; specifically identify who reports and why, must include family input.		
<b>Strengths:</b>	<i>(Based on interview, observation, and assessment results, what skills does the child currently display?)</i>	
<b>Needs (linked to assessment results):</b>	<i>(Based on interview, observation, and assessment results, with which skills does the child currently need assistance?)</i>	
<b>Sub domains (Describe): Identify which sub-domain will be addressed, Autism Specialist must have a minimum of one per sub-domain</b>		
	<b>Description</b>	
<b>Sub Domain:</b>	Linked to Domain – must be specific, identify a specific skill set within the domain	
<b>Current Level of Performance:</b>	Describe in specific observable and measurable terms the child's behavior/skill level with the sub-domain.	
<b>Objective:</b>	Describe in specifics observable and measurable terms the goal with the sub-domain.	
<b>Child's Existing Supportive Skills:</b>	Skills that child currently exhibits that are the basic, core or related skills needed in order to address this objective.	
<b>Data Collection and Supportive Documentation:</b>	Method and measures that will be utilized to measure progress toward this objective. Collected data must include a minimum of one of following types: frequency, duration; intensity, or latency. Supportive documentation may include graphs, charts, and figures demonstrating progress.	
<b>Plan for Generalization:</b>	Describe how this skill will be taught and measured across multiple environments/settings and multiple people.	
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	Indicate the date (mm/dd/yyyy ) that revision or reviews were made. Document the change to the domain with notes.	
<b>Date Mastered and Next Steps:</b>	Indicate when the child has mastered the skill identified in the sub-domain and indentify what is the next task /skill the child will work on.	

Section II

Child's Name: \_\_\_\_\_

Date: \_\_\_\_\_

<b>Domain:</b>	<b>Behavior</b>	<b>Goal #</b>
<b>Summary (with family input):</b>		
<b>Strengths:</b>		
<b>Needs (linked to assessment results):</b>		
<b>Sub-domains (address a minimum of 1): Compliance, Challenging Behaviors, Stereotypic Behavior, Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>		
<b>Current Level of Performance:</b>		
<b>Objective:</b>		
<b>Child's Existing Supportive Skills:</b>		
<b>Data Collection and Supportive Documentation:</b>		
<b>Plan for Generalization:</b>		
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>		
<b>Date Mastered and Next Steps:</b>		

<b>Domain:</b>		<b>Communication: Expressive</b>	<b>Goal #</b>
<b>Summary (with family input):</b>			
<b>Strengths:</b>			
<b>Needs (linked to assessment results):</b>			
<b>Sub domains (address a minimum of 1): Requesting (Manding), Labeling (Tacts), Conversational Skills, Spontaneous Vocalizations, Syntax and Grammar, Information Recall and Initiations, Other (please specify)</b>			
	<b>Description</b>		
<b>Sub Domain:</b>			
<b>Current Level of Performance:</b>			
<b>Objective:</b>			
<b>Child's Existing Supportive Skills:</b>			
<b>Data Collection and Supportive Documentation:</b>			
<b>Plan for Generalization:</b>			
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>			
<b>Date Mastered and Next Steps:</b>			

Section II  
 Child's Name:

Date:

<b>Domain:</b>		<b>Communication: Nonverbal</b>	<b>Goal #</b>
<b>Summary (with family input):</b>			
<b>Strengths:</b>			
<b>Needs (linked to assessment results):</b>			
<b>Sub domains (address a minimum of 1): Emotions, Affect, Proximity, Reading Social Cues, Using Nonverbal Cues, Voice Intonation, Other (please specify)</b>			
	<b>Description</b>		
<b>Sub Domain:</b>			
<b>Current Level of Performance:</b>			
<b>Objective:</b>			
<b>Child's Existing Supportive Skills:</b>			
<b>Data Collection and Supportive Documentation:</b>			
<b>Plan for Generalization:</b>			
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>			
<b>Date Mastered and Next Steps:</b>			

<b>Domain:</b>		<b>Communication: Receptive</b>	<b>Goal #</b>
<b>Summary (with family input):</b>			
<b>Strengths:</b>			
<b>Needs (linked to assessment results):</b>			
<b>Sub domains (address a minimum of 1): Labeling (identifies nouns, objects, verbs), Follows Instructions (follows 1 step, 2 step, novel instructions), Other (please specify)</b>			
	<b>Description</b>		
<b>Sub Domain:</b>			
<b>Current Level of Performance:</b>			
<b>Objective:</b>			
<b>Child's Existing Supportive Skills:</b>			
<b>Data Collection and Supportive Documentation:</b>			
<b>Plan for Generalization:</b>			
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>			
<b>Date Mastered and Next Steps:</b>			

Section II  
 Child's Name:

Date:

<b>Domain:</b>		<b>Community: Readiness Skills</b>	<b>Goal #</b>
<b>Summary (with family input):</b>			
<b>Strengths:</b>			
<b>Needs (linked to assessment results):</b>			
<b>Sub domains (address a minimum of 1): Waiting Skills, Following Routines, Group Instruction, Information Retention, Circle Time Skills, Activity Transitions, Other (please specify)</b>			
	<b>Description</b>		
<b>Sub Domain:</b>			
<b>Current Level of Performance:</b>			
<b>Objective:</b>			
<b>Child's Existing Supportive Skills:</b>			
<b>Data Collection and Supportive Documentation:</b>			
<b>Plan for Generalization:</b>			
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>			
<b>Date Mastered and Next Steps:</b>			

Section II  
 Child's Name:

Date:

<b>Domain:</b>	<b>Concept Formation Skills</b>	<b>Goal #</b>
<b>Summary (with family input):</b>		
<b>Strengths:</b>		
<b>Needs (linked to assessment results):</b>		
<b>Sub domains (address a minimum of 1): Matching, Sequencing, Puzzles, Patterns, Colors/Shapes/Size, Categories, Problem Solving, Preschool Skills (prepositions, colors, numbers, counting, computer skills), Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>		
<b>Current Level of Performance:</b>		
<b>Objective:</b>		
<b>Child's Existing Supportive Skills:</b>		
<b>Data Collection and Supportive Documentation:</b>		
<b>Plan for Generalization:</b>		
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>		
<b>Date Mastered and Next Steps:</b>		

Section II  
 Child's Name:

Date:

<b>Domain: Family Environment</b>		<b>Goal #</b>
<b>Summary (with family input):</b>		
<b>Strengths:</b>		
<b>Needs (linked to assessment results):</b>		
<b>Sub domains (address a minimum of 1): Schedule, Family Participation, Legal/Financial Considerations, Support Needs, Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>		
<b>Current Level of Performance:</b>		
<b>Objective:</b>		
<b>Child's Existing Supportive Skills:</b>		
<b>Data Collection and Supportive Documentation:</b>		
<b>Plan for Generalization:</b>		
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>		
<b>Date Mastered and Next Steps:</b>		

<b>Domain: Imitation and Attending</b>		<b>Goal #</b>
<b>Summary (with family input):</b>		
<b>Strengths:</b>		
<b>Needs (linked to assessment results):</b>		
<b>Sub domains (address a minimum of 1): Responds to name, Gross Motor Movements, Fine Motor Movements, Movements with objects, Oral Motor Movements, Movements paired with sounds, Peer movements, Sequence of movements, Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>		
<b>Current Level of Performance:</b>		
<b>Objective:</b>		
<b>Child's Existing Supportive Skills:</b>		
<b>Data Collection and Supportive Documentation:</b>		
<b>Plan for Generalization:</b>		
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>		
<b>Date Mastered and Next Steps:</b>		

Section II  
 Child's Name:

Date:

Domain	Leisure/Recreation/Play	Goal #
<b>Summary (with family input):</b>		
<b>Strengths:</b>		
<b>Needs (linked to assessment results):</b>		
<b>Sub domains (address a minimum of 1): Independent Play, Imaginary Play, Block Play, Symbolic Play, Playing Games (board, socially interactive, computer based), Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>		
<b>Current Level of Performance:</b>		
<b>Objective:</b>		
<b>Child's Existing Supportive Skills:</b>		
<b>Data Collection and Supportive Documentation:</b>		
<b>Plan for Generalization:</b>		
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>		
<b>Date Mastered and Next Steps:</b>		

Section II  
 Child's Name:

Date:

Domain	Motor Skills	Goal #
<b>Summary (with family input):</b>		
<b>Strengths:</b>		
<b>Needs (linked to assessment results):</b>		
<b>Sub domains (address a minimum of 1): Fine Motor, Gross Motor, Hand/eye Coordination, Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>		
<b>Current Level of Performance:</b>		
<b>Objective:</b>		
<b>Child's Existing Supportive Skills:</b>		
<b>Data Collection and Supportive Documentation:</b>		
<b>Plan for Generalization:</b>		
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>		
<b>Date Mastered and Next Steps:</b>		

Section II  
 Child's Name:

Date:

Domain	Self- Help Skills	Goal #
<b>Summary (with family input):</b>		
<b>Strengths:</b>		
<b>Needs (linked to assessment results):</b>		
<b>Sub domains (address a minimum of 1): Dressing/Undressing, Eating, Toilet Training, Health/Hygiene/Grooming, Independence/Self-monitoring, Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>		
<b>Current Level of Performance:</b>		
<b>Objective:</b>		
<b>Child's Existing Supportive Skills:</b>		
<b>Data Collection and Supportive Documentation:</b>		
<b>Plan for Generalization:</b>		
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>		
<b>Date Mastered and Next Steps:</b>		

Section II  
 Child's Name:

Date:

Domain	Social Interactions	Goal #
<b>Summary (with family input):</b>		
<b>Strengths:</b>		
<b>Needs (linked to assessment results):</b>		
<b>Sub domains (address a minimum of 1): Joint Attention and Social Referencing, Eye Contact in Conversations, Adult Social Interactions, Complex Social Interactions, Initiating and Maintaining Conversations, Social Nuances, Relationship Development, Peer Social Interactions, Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>		
<b>Current Level of Performance:</b>		
<b>Objective:</b>		
<b>Child's Existing Supportive Skills:</b>		
<b>Data Collection and Supportive Documentation:</b>		
<b>Plan for Generalization:</b>		
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>		
<b>Date Mastered and Next Steps:</b>		

**Section III – Circle of Support**

**Child’s name:**

**Date:**

**Emergency Contacts** - (In the event of an evacuation or scheduled staff is not available to work, who would be your emergency contact and/or back up plan to care for your child. Please list in order of priority.

1. Name	Address	Phone & Alternative Number	Relationship to child

**List the members of your household**

2. Name	Address	Phone & Alternative Number	Relationship to child

**Additional Non-Waiver Support /Services from Family, Friend, Neighbor, Church,**

3. Name	Relationship (check if primary caregiver)	Address	Phone	Service	Frequency	Paid	
						Yes	No

**HOME & COMMUNITY-BASED SERVICES FOR AUTISM SERVICES  
PLAN OF CARE**

1. POC Approval Date \_\_\_\_\_

2. Child's name: \_\_\_\_\_ SS#: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ County \_\_\_\_\_

Identified Autism Specialist: \_\_\_\_\_ Provider Number \_\_\_\_\_ Phone# \_\_\_\_\_ Vineland II Assessment Date \_\_\_\_\_

**3. Plan of Care**

Waiver Services	Procedure Code	Provider Number	Provider Name	Units (15 min. = 1 unit)	Frequency	Total Units Monthly	Services Start Date	Services End Date	Discharge code	Cost Of Unit	Monthly Cost
<b>Total Monthly Waiver Cost</b>											

4. Client Obligation Amount if Applicable (assign to a specific provider) \$ \_\_\_\_\_

5. Assigned Provider(s) number. \_\_\_\_\_ (1) \_\_\_\_\_ (2)

Release of Information: I consent to the release of the information on this page so my child can receive Autism Waiver services. I understand the information included in this document will be release to Waiver Service Providers listed above to enable the delivery of services and program monitoring. I understand a electronic transmit of information such as a webcam maybe used as a means to deliver services. My signature on this form also certifies that I agree to and helped develop this plan of care.

**6. Signatures**

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Autism Specialist

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Print Name

\*\*\*\*Signature must be legible \*\*\*\*

**Section V – Participant Signature Page**

**Child’s name:**

**Date:**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

**HOME & COMMUNITY-BASED SERVICES FOR AUTISM SERVICES  
PLAN OF CARE**

1. POC Approval Date \_\_\_\_\_

2. Child's name: \_\_\_\_\_ SS#: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ County \_\_\_\_\_

Identified Autism Specialist: \_\_\_\_\_ Provider Number \_\_\_\_\_ Phone# \_\_\_\_\_ Vineland II Assessment Date \_\_\_\_\_

**3. Plan of Care**

Waiver Services	Procedure Code	Provider Number	Provider Name	Units (15 min. = 1 unit)	Frequency	Total Units Monthly	Services Start Date	Services End Date	Discharge code	Cost Of Unit	Monthly Cost
<b>Total Monthly Waiver Cost</b>											

4. Client Obligation Amount if Applicable (assign to a specific provider) \$ \_\_\_\_\_

5. Assigned Provider(s) number. \_\_\_\_\_ (1) \_\_\_\_\_ (2)

Release of Information: I consent to the release of the information on this page so my child can receive Autism Waiver services. I understand the information included in this document will be release to Waiver Service Providers listed above to enable the delivery of services and program monitoring. I understand a electronic transmit of information such as a webcam maybe used as a means to deliver services. My signature on this form also certifies that I agree to and helped develop this plan of care.

**6. Signatures**

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Autism Specialist

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Print Name

\*\*\*\*Signature must be legible \*\*\*\*

Child Name:

Date:

AW-006

<b>Domain:</b>		<b>Goal #</b>
<b>Summary (with family input):</b>		
<b>Strengths:</b>		
<b>Needs (linked to assessment results):</b>		
<b>Sub-domains (address a minimum of 1):</b>		
	<b>Description</b>	
<b>Sub Domain:</b>		
<b>Current Level of Performance:</b>		
<b>Objective:</b>		
<b>Child's Existing Supportive Skills:</b>		
<b>Data Collection and Supportive Documentation:</b>		
<b>Plan for Generalization:</b>		
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>		
<b>Date Mastered and Next Steps:</b>		

## Request for Extension/ Statement of need for HCBS Autism Waiver Services

Since Kansas has chosen to focus on an HCBS Autism early intensive intervention Waiver in order to have a greater impact on the lives of those children with an Autism Spectrum Disorder these services are limited to 3 years unless medically necessary. At the end of three years, if the Autism Specialist and family believe it is medically necessary to continue with waiver services because the child has demonstrated continued improvement and would likely continue to improve with the extension, a request for a one time, one year extension can be made. The following information will be required if an extension is being requested.

**All requests must be submitted no later than 120 days before the child meets their service limits.**

### Documentation for extension HCBS Autism Waiver services

1. All Vineland Scores and Criterion Reference Skill Based assessment (CRSBA) summaries
2. Current IBP/POC.
3. Statement of need by the Autism Specialist including;
  - a. Summary of data based progress and current areas of need
  - b. Identify the 3 goals that will be worked on if the extension of services is granted, (goals should be identified by the Autism Specialist and parents as a team).
  - c. Parents need to sign a statement they are requesting consideration for an additional year of Autism Waiver services for \_\_\_\_\_.  
(Child)
4. Complete the chart below;

	Service Category	Have you used this service?	Hours used last month	Barriers (i.e. lack of provider, serious illness/injury, etc.)
	Intensive Individual Supports	Y N		
	Respite	Y N		
	Parent Support and Training	Y N		
	Family Adjustment Counseling	Y N		
	Autism Specialist	Y N		
	Interpersonal Communication Therapy	Y N		

# Request for Extension/ Statement of need for HCBS Autism Waiver Services

## Statement of Need by Autism Specialist

My signature below indicates that I am requesting consideration for an additional year of HCBS/Autism Waiver Services for my child. I am aware that this request and all supporting documentation will be utilized for the reviewed process which will include a team of three individuals not directly involved in providing services for my child, \_\_\_\_\_.  
(Child's name)

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Autism Specialist

\_\_\_\_\_  
Date

## Autism Waiver Review Team Form

### Recommendation for Extension of Services

<b>Date of Initial Vineland:</b>
----------------------------------

Child's Name:	Medicaid Number:	Date of Review:
Autism Reviewer:		
Meet criteria for extension waiver services to continue: Yes <input type="checkbox"/> No <input type="checkbox"/>		

Documentation for extension of HCBS Waiver services provided? (Yes or No)

All Vineland Scores & Criterion Reference Skill Assessment summaries

Current IBP/POC

Summary of data based progress

Request for Extension /Statement of need signed by both the Autism Specialist and parent.

Criteria for determining Medical Necessity

IBP- Global Risk Rating Score (minimum 14 has to be met)

Did the family use 2 waiver services on an ongoing basis? (Yes or No)

Did the child utilize at least 20% of available waiver services in the previous 365 days? (Yes or No)

Compare Adaptive skills from the initial Vineland to the most recent Vineland and did the child show improvement in any 2 adaptive raw scores. (Yes or No)

If the child did not meet the criteria for utilizing 20% of available waiver service and/ or , the criteria regarding the Adaptive skills score listed above, the team can use one or a combination of the following items as a determining factor to demonstrate a continue need for services;

- Criterion Reference Skill Based Assessment (CRSBA) summary
- Additional data sheet for the last 6 months, please be concise with your information.
- Progress reports

Please indicate which items listed above was a determining factor to demonstrate a continued need for services.

Comments and/or notes by reviewer:

Reviewer's Name

Date

\_\_\_\_\_  
Signature

*Reviewer sends a copy of the review form to the Autism Program Manager. Reviewer keeps this form for 30 days in case of an appeal, and if there is no appeal after 30 days then reviewer must destroy their file of this review.*

## INFORMATION DISCLOSURE FORM

### Parent Fee Program – Home and Community Based Services (HCBS) Waiver

**A. Child(ren) Information**

Please complete the following for each child under the age of 18 receiving services through a HCBS Waiver.

Child's Full Name (First, Middle Initial, Last)	Date of Birth (Mo/Day/year)	Medicaid ID Number	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check the appropriate line below to indicate in which HCBS waiver your child(ren) are enrolled:

- DD Waiver** for Children with Mental Retardation or a Developmental Disability  
 **TA Waiver** Technology Assistance for Children who depend on technology for life  
 **SED Waiver** for Children with a Severe Emotional Disturbance

**B. Parent Information**

Name of Parent(s): \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Daytime Phone Number (\_\_\_\_\_) \_\_\_\_\_ Parent's SSN: \_\_\_\_\_

1. Were you required to file a federal income tax return for last year?      Yes \_\_\_\_      No \_\_\_\_
2. If "Yes", please attach a copy of the first page of your Federal Income Tax Return. If "No", please estimate, below.
3. Total Number of Exemptions Claimed # \_\_\_\_\_ Adjusted Gross Income \$ \_\_\_\_\_

I do not believe a Parent Fee should be charged for the following reason(s). Check **all** that apply.

- Child is over 18                               Child is in foster care or some other residential placement  
 Child is adopted                               I am a relative other than a parent or step-parent  
 Waiver has been officially discontinued with an effective date of \_\_\_\_/\_\_\_\_/\_\_\_\_

**C. The information I have given on this form is true and correct to the best of my knowledge.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please mail to: SRS, Health Care Policy - Parent Fee Program  
 915 SW Harrison, DSOB 10<sup>th</sup> Floor  
 Topeka, KS 66612-1570

**Contact for Questions**  
 Phone: (785) 296-3536

**NOTIFICATION OF HCBS OR WORKING HEALTHY SERVICES  
REFERRAL/INITIAL ELIGIBILITY/ASSESSMENT/SERVICES INFORMATION**

TO: \_\_\_\_\_ FROM: \_\_\_\_\_

**I. CONSUMER INFORMATION:**

Name: \_\_\_\_\_ Medicaid ID No: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Responsible Person/Contact: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**II. ELIGIBILITY INFORMATION: (to be completed by EES Specialist or Social Worker)**

Working Healthy Referral  WORK Referral  Eligibility Information  HCBS Referral

EES Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Medicaid Application: Date: \_\_\_\_\_ Case #: \_\_\_\_\_

Status:  Pending  Denial/Ineligible  
 Non-HCBS Approval (check one)  Medical Card  Spenddown Amount  QMB/LMB Only  
 Working Healthy Approval, effective date \_\_\_\_\_ Premium(s): \_\_\_\_\_  
 WORK approval, effective date \_\_\_\_\_  
 HCBS Approved, effective date \_\_\_\_\_ HCBS Obligation: \_\_\_\_\_ Month: \_\_\_\_\_

Next Review Date: \_\_\_\_\_ HCBS Obligation: \_\_\_\_\_ Month: \_\_\_\_\_

Comments: \_\_\_\_\_

**III. HCBS INFORMATION: (to be completed by Case Manager/IL Counselor)**

Medicaid Referral  Service Information

Case Manager/ILC: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_

HCBS Waiver Type: \_\_\_\_\_ Placed on Waiting List:  Yes, Date: \_\_\_\_\_  No

Waiver/LOC Threshold Met?  Yes  No Request Withdrawn  Yes  No

Chooses HCBS:  Yes, Date: \_\_\_\_\_  No Monthly Cost (excluding average acute care costs): \_\_\_\_\_

Effective Date of HCBS Services (Approved By Program Manager or Other Authority): \_\_\_\_\_

WORK Service:  Approved  Denied Start Date: \_\_\_\_\_

Comments: \_\_\_\_\_

**4. WORKING HEALTHY INFORMATION (to be completed by Benefits Specialist)**

Benefits Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Chooses Working Healthy:  No  Yes, date \_\_\_\_\_

Premium Discussed  No  Yes, Willing To Pay Prior Medical Premium  No  Yes Current Premium  No  Yes

Comments: \_\_\_\_\_

ELIGIBILITY WORKER SIGNATURE

DATE

YES  NO  
ATTACHMENTS

HCBS AUTHORIZED AGENT SIGNATURE

DATE

**NOTIFICATION OF HCBS OR WORKING HEALTHY SERVICES  
REFERRAL/INITIAL ELIGIBILITY/ASSESSMENT/SERVICES INFORMATION**

**TO:** Local SRS EES worker **FROM:** Functional Eligibility Specialist & (phone number)

**I. CONSUMER INFORMATION:**

Name: Annie Sue Jones Medicaid ID No: 001000000000  
 Address: 1111 High St, Somewhere, Kansas 666612  
 Phone: 785-233-0000 SSN: 000-00-0000 Date of Birth: 06/19/06  
 Responsible Person/Contact: Mrs. Jones Home Phone: 785-233-0000  
 Address: Same as above Work Phone: If there is one

**II. ELIGIBILITY INFORMATION: (to be completed by EES Specialist or Social Worker)**

Working Healthy Referral  WORK Referral  Eligibility Information  HCBS Referral

EES Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Medicaid Application: Date: \_\_\_\_\_ Case #: \_\_\_\_\_

Status:  Pending  Denial/Ineligible  
 Non-HCBS Approval (check one)  Medical Card  Spenddown Amount  QMB/LMB Only  
 Working Healthy Approval, effective date \_\_\_\_\_ Premium(s): \_\_\_\_\_  
 WORK approval, effective date \_\_\_\_\_  
 HCBS Approved, effective date \_\_\_\_\_ HCBS Obligation: \_\_\_\_\_ Month: \_\_\_\_\_

Next Review Date: \_\_\_\_\_ HCBS Obligation: \_\_\_\_\_ Month: \_\_\_\_\_

Comments: \_\_\_\_\_

**III. HCBS INFORMATION: (to be completed by Case Manager/IL Counselor)**

Medicaid Referral  Service Information

Case Manager/ILC: Functional Eligibility Specialist Phone: 785-233-0001

Address: Sugar Plum St., Topeka, KS 66612 Fax: 785233-0002

HCBS Waiver Type: Autism Placed on Waiting List:  Yes, Date: \_\_\_\_\_  No

Waiver/LOC Threshold Met?  Yes  No Request Withdrawn  Yes  No

Chooses HCBS:  Yes, Date: 04/01/09  No Monthly Cost (excluding average acute care costs): \_\_\_\_\_

Effective Date of HCBS Services (Approved By Program Manager or Other Authority): 04/01/09 (same date of assessment)

WORK Service:  Approved  Denied Start Date: \_\_\_\_\_

Comments: Autism Specialist contact information. If an Autism Specialist is still unknown at this time put in Autism Program Manager's information

**4. WORKING HEALTHY INFORMATION (to be completed by Benefits Specialist)**

Benefits Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Chooses Working Healthy:  No  Yes, date \_\_\_\_\_

Premium Discussed  No  Yes, Willing To Pay Prior Medical Premium  No  Yes Current Premium  No  Yes

Comments: \_\_\_\_\_

YES  NO

ELIGIBILITY WORKER SIGNATURE

DATE

ATTACHMENTS

Functional Eligibility Specialist

04/01/09

HCBS AUTHORIZED AGENT SIGNATURE

DATE



NOTIFICATION OF MEDICAID/HCBS/WORKING HEALTHY SERVICES  
CHANGES / UPDATES

ES-3161  
Rev. 7-07

TO: \_\_\_\_\_ FROM: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

**I. CONSUMER INFORMATION:**

Name: \_\_\_\_\_  
Case Number (If Known): \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
Address Change: \_\_\_\_\_ Date: \_\_\_\_\_  
Responsible Person or Alternate Contact Change: \_\_\_\_\_ Date: \_\_\_\_\_

**II. SRS MEDICAID INFORMATION CHANGES: (to be completed by EES Specialist or Social Worker)**

Review Complete:  Approved / Denied  Working Healthy/WORK - Temporary Unemployment Plan Needed.  
Eff Date: \_\_\_\_\_ Next Review: \_\_\_\_\_ Date Last Employed \_\_\_\_\_  
 HCBS Obligation Change: \$ \_\_\_\_\_ Eff: \_\_\_\_\_ Reason for Unemployment \_\_\_\_\_  
\$ \_\_\_\_\_ Eff: \_\_\_\_\_  
 Medicaid Case Close Eff: \_\_\_\_\_ Reason: \_\_\_\_\_  
 HCBS Client Employed (possible Working Healthy/WORK eligible):  
 Other: \_\_\_\_\_  
Comments: \_\_\_\_\_

**III. HCBS SERVICE CHANGES: (to be completed by Case Manager/IL Counselor/WORK Manager)**

HCBS/WORK Services Review: Approved/Denied \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Level of Care Waiver Change To: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Monthly Cost of Services Change To: \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 HCBS/WORK Services Terminated -Effective Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Medical Bills for Obligation (Bills Attached)  
 NF Entrance: Date Entered: \_\_\_\_\_ Facility: \_\_\_\_\_ Anticipated Length of Stay \_\_\_\_\_  
Check one:  HCBS-Covered Respite  Temporary Care  Permanent/Undetermined  
 Other: \_\_\_\_\_  
Comments: \_\_\_\_\_

**IV. WORKING HEALTHY INFORMATION (to be completed by Benefits Specialist)**

Temporary Unemployment Plan Info:  Client Failed to Comply, Reason \_\_\_\_\_  Plan Developed  
Premium Repayment:  Agreement Signed, Date Received \_\_\_\_\_  
Other: \_\_\_\_\_  
Comments: \_\_\_\_\_

\_\_\_\_\_  
EES SPECIALIST/SOCIAL WORKER SIGNATURE DATE ATTACHMENTS:  YES  NO

\_\_\_\_\_  
CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE DATE

This form supersedes IM-3161 (1-98)

**NOTIFICATION OF MEDICAID/HCBS/WORKING HEALTHY SERVICES  
CHANGES / UPDATES**

ES-3161  
Rev. 7-07

**TO:** Local SRS EES Worker **FROM:** FES / Autism Specialist  
**ADDRESS:** 500 Van Buren **ADDRESS:** 003 Sugar Pie Lane  
Topek, Ks 66611 Lawrence, Ks. 66047

**I. CONSUMER INFORMATION:**

Name: John Smith  
Case Number (If Known): \_\_\_\_\_ Medicaid ID #: 001002003004  
Address Change: N/A Date: N/A  
Responsible Person or Alternate Contact Change: Mrs. Smith Date: 02/15/2009

**II. SRS MEDICAID INFORMATION CHANGES: (to be completed by EES Specialist or Social Worker)**

Review Complete:  Approved / Denied  Working Healthy/WORK - Temporary Unemployment Plan Needed.  
Eff Date: \_\_\_\_\_ Next Review: \_\_\_\_\_ Date Last Employed: \_\_\_\_\_  
 HCBS Obligation Change: \$ \_\_\_\_\_ Eff: \_\_\_\_\_ Reason for Unemployment \_\_\_\_\_  
\$ \_\_\_\_\_ Eff: \_\_\_\_\_  
 Medicaid Case Close Eff: \_\_\_\_\_ Reason: \_\_\_\_\_  
 HCBS Client Employed (possible Working Healthy/WORK eligible):  
 Other: \_\_\_\_\_  
Comments: \_\_\_\_\_

**III. HCBS SERVICE CHANGES: (to be completed by Case Manager/IL Counselor/WORK Manager)**

HCBS/WORK Services Review: Approved/Denied approved or denied Effective Date: \_\_\_\_\_ Month of the initial assessment \_\_\_\_\_  
 Level of Care Waiver Change To: \_\_\_\_\_ Transfer from one waiver to another \_\_\_\_\_ Effective Date: \_\_\_\_\_ Agreed upon date of transfer \_\_\_\_\_  
 Monthly Cost of Services Change To: \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 HCBS/WORK Services Terminated -Effective Date: \_\_\_\_\_ Last day of services \_\_\_\_\_ Reason: Met service limits/ moved  
 Medical Bills for Obligation (Bills Attached)  
 NF Entrance: Date Entered: \_\_\_\_\_ Facility: \_\_\_\_\_ Anticipated Length of Stay \_\_\_\_\_  
Check one:  HCBS-Covered Respite  Temporary Care  Permanent/Undetermined  
 Other: Autism Specialist information  
Comments: \_\_\_\_\_

**IV. WORKING HEALTHY INFORMATION (to be completed by Benefits Specialist)**

Temporary Unemployment Plan Info:  Client Failed to Comply, Reason \_\_\_\_\_  Plan Developed \_\_\_\_\_  
Premium Repayment:  Agreement Signed, Date Received \_\_\_\_\_  
Other: \_\_\_\_\_  
Comments: \_\_\_\_\_

YES  NO

EES SPECIALIST/SOCIAL WORKER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ ATTACHMENTS: \_\_\_\_\_

CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Recording information on the Individualized Behavioral Program/Plan of Care Instrument (IBP/POC).

- Child's name and date is completed on every page of the IBP/POC
- All paperwork is legible.
- Those items or sections that are not applicable to a particular child may be left blank.  
For example, in Section I under Autism Specialist information if the provider is an independent provider, then the Autism Specialist would not need to complete the information pertaining to an agency.
- Each domain may include the following dates:
  - a. Implementation
  - b. Review/Revision every six (6) months
  - c. Completion
- If revision is needed within a domain (whiteout is not acceptable) each domain sheet will include:
  - a. Date of revision
  - b. Can use additional domain sheets as necessary for clarity of case flow.
  - c. Always keep the original in the case file.
- The IBP/POC identifies the level of needs the child has.
- The IBP/POC is completed by the Autism Specialist with direct input from the family and/or others the family have identified.
- The child/family has the right to choose their providers for all waiver services including the Autism Specialist.
- All signatures must be legible.

The IBP/POC is completed at a minimum annually. Post implementation of the POC includes monitoring and follow-up activities and a review of the IBP/POC at a minimum of every six months with documentation of progress toward stated goals. If progress is not demonstrated, documentation must support a reason for pursuing these goals or a change in the goals must be made.

### **Sources of Information**

To accurately complete the IBP/POC the Autism Specialist will need to obtain information from a variety of sources.

Sources of information for accurate completion of the assessment process are listed below:

- Primary sources may include the child/parent/guardian.

- Talk with and observe the child (if applicable). Use appropriate interview techniques based on age of the child and the family situation.
- Other sources may include Teachers, Mental Health Professionals, Day Care personnel, neighbors, and extend family members providing the parent/guardian has identified/ and given the Autism Specialist permission to contact them.

*Remember the child and or family are included, consulted and the driving force in the decision-making process in developing the IBP/POC.*

## **Section I – page 1**

### **1. Date of IBP/POC: Document**

- The date of IBP/POC is completed
- Indicate whether this is an initial, revision, annual IBP/POC or an exception request for an extension of one year. Exceptions can be requested after the child has completed the third year on the waiver.

### **2. Child's Information: Document**

- The child's full legal name (first name, last name & middle initial).
- Medicaid Number - the eleven (11) digit number found on the child's Medicaid Card
- Social Security Number assigned by SSA to the child.
- The child's home address, including county, state, zip, and phone number. In some areas, a child/family will only have a mailing address, such as a post office box, and not have a residence address. If this is so, put this mailing address in the residence address section.
- The child's date of birth and indicate gender by circling either M or F.

### **3. Parent/Legal Guardian Information: Document**

- The parent/guardian's name and home address, even if it is the same as the child's listed above. Include county, state, zip, and phone number.
- Indicate whether the child is with their natural/adopted parents, foster parents, guardian, or SRS custody.

**4. Autism Specialist Information: Document**

- Autism Specialist full name per his/her Medicaid Provider enrollment form.
- Autism Specialist needs to provide his/her Medicaid Provider number.
- Autism Specialist provides his/her work number and fax number where they can be reached.
- Autism Specialist's work address (if Autism Specialist is an independent provider, put home and/or office address), City, County, State, and Zip.
- Autism Specialist's will provide an email address.
- Autism Specialist's will indicate whether they are an independent provider or employed by an agency.

**5. Agency Information: Document (If applicable)**

*If the Autism Specialist is employed by an agency this section needs to be completed.*

- The agency's name for which the Autism Specialist is employed.
- The agency's business phone & fax number.
- Provide the business address of the agency, city, county, state, and zip.
- Autism Specialist indicates which type of provider best describes your agency.

**6. Assessment Score & Diagnosis: Document**

- The date on the Vineland II was completed by the Functional Eligibility Specialist.
- Review the scores from the Vineland, and then transfer the scores to the appropriate Adaptive and Maladaptive areas.
- The child's diagnosis as indicated on screening.

**Section I – page 2**

**7. Criterion Reference Skilled Based Assessment: Document**

- Name of the type of assessment tool that was utilized to measure behaviors and behavior change based on a defined level of performance.

**8. Treatment options: Document**

- Which evidence-based method will be use, or planned for use. If “Other” is indicated, it too must be an evidenced-based practice and the name of the treatment must be clearly identified.

**9. Classroom or Educational Setting: Document**

- Indicate any mandated services the child receives such as Part B or C of IDEA.
- If **yes**, provide name of school/service.
- If **yes**, the child attends school provide the grade level the child is currently at.

**10. Behavior Impact Rating Tool: Document**

- The interviewer will ask the parents to rate their child’s behavior using a scale rating of 1 to 6 or NA. Parents should base their responses on the child’s worst day. Each question is to be answered with a number 1 through 6 or NA.
- On lines 1 through 5 list what the parents view as the 5 highest priorities they would like addressed.
- On lines 1 through 3 list have parents identify 3 problem behaviors to address.

**11. Global Risk Rating Scales: Document**

- Considering the previous information the parents and Autism Specialist will answer these questions as a team taking into consideration all they know about the child’s entire behavioral repertoire to answer each question.

**Section II – page 1**

*This section addresses twelve (12) life domains of the child. Each domain must be addressed. Under each domain there are several sub-domains listed; at least one of those listed sub-domains must also be addressed. Additional sub-domains may be documented by using additional sheets if desired.*

*A documented review of domains should be conducted by the Autism Specialist at least every 6 months.*

<b>Domain: Identify which life domains will be addressed</b>		<b>Goal#:</b>
<b>Summary (with family input):</b> A general overview of the child’s performance within this domains; specifically identify who reports and why, must include family input.		
<b>Strengths:</b>	<i>(Based on interview, observation, and assessment results, what skills does the child currently display?)</i>	
<b>Needs (linked to assessment results):</b>	<i>(Based on interview, observation, and assessment results, with which skills does the child currently need assistance?)</i>	
<b>Sub domains (Describe): Identify which sub-domain will be addressed, Autism Specialist must have a minimum one per sub-domain</b>		
	<b>Description</b>	
<b>Sub -Domain:</b>	Linked to Domain – must be specific, identify a specific skill set within the domain	
<b>Current Level of Performance:</b>	Describe in specific observable and measurable terms the child’s behavior/skill level with the sub-domain.	
<b>Objective:</b>	Describe in specifics observable and measurable terms the goal with the sub-domain.	
<b>Child’s Existing Supportive Skills:</b>	Skills that child currently exhibits that are the basic, core or related skills needed in order to address this objective.	
<b>Data Collection and Supportive Documentation:</b>	Method and measures that will be utilized to measure progress toward this objective. Collected data must include a minimum of one of following types: frequency, duration; intensity, or latency. Supportive documentation may include graphs, charts, and figures demonstrating progress.	
<b>Plan for Generalization:</b>	Describe how this skill will be taught and measured across multiple environments/settings and multiple people.	
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	mm/dd/yyyy Indicate the date that revision or reviews were made. Document the change to the domain with notes.	
<b>Date Mastered and Next Steps:</b>	Indicate when the child has mastered the skill identified in the sub-domain and identify what the next task /skill is the child will work on.	

## **Section III - page 1**

### **1. Emergency Contacts: Document**

- List two emergency contacts in order of priority; name, give the address, phone & alternative phone number, and relationship to the child.

### **2. List the members of your household: Document**

- Indicate who is living in the household; name, address, phone & Alternative Number, and relationship to child.

### **3. Non-Waiver Supports: Document**

- List the name of the individual providing the service, what is their relationship to the child, address, phone number, what services is performed, frequency (how often) is the services provided, and does the primary care giver pays for services.

## **Section IV- Plan of Care**

### **1. POC Approval Date: Document**

- Date the POC was approved on the MMIS by the Autism Program Manager.

### **2. Demographics: Document**

- Child's full legal name (first, last name & middle initial).
- Social Security Number assigned by SSA to the child.
- Medicaid Number - the eleven (11) digit number found on the child's Medicaid Card
- Date of Birth (DOB)
- Address of child's residence
- City of child's residence
- Zip Code
  - County of child's residence
  - Identified Autism Specialist

- Autism Specialist provider number
- Autism Specialist phone number
- Date the Vineland II was completed by the Functional Eligibility Specialist.

**3. Plan of Care: Document**

- Waiver Services - indicate which waiver service will be used; Intensive Individual Supports(IIS), Respite Care (RC), Parent Support and Training (PS), or Family Adjustment Counseling (FAC).
- Procedure Code - List the procedure code associated with the waiver service be used.
- Provider Number – List the provider number of the person providing the service.
- Provider Name – Write the name of the provider.
- Units – Each unit equals fifteen (15) minutes, indicate how many units will be used for a monthly (31 day) plan.
- Frequency – Identify how often will the waiver service: 3x/wk; weekly; monthly; or specify another frequency.
- Total Units Monthly – Indicate how many units will be used per month.
- Services Start Date – The date child start receiving services; mm/dd/yy
- Services End Date – Date services will end,
- Discharge code - Identify discharge code in Section G-5 in the Autism Policy & Procedure Manual when closing the entire POC.
- Cost of Unit – Indicate the rate of pay per unit for waiver service.
- Monthly Cost – The monthly cost will be the service rate amount times frequency. Example; If daily, cost per unit x # of unit per day x31. If service is provided less than daily, adjust the number of days in the month accordingly.
- Total Monthly Waiver Cost – Add the total monthly waiver costs and enter the figure in this space.

**4. Client Obligation: Document**

- If applicable, record the dollar amount.

**5. Assigned Provider: Document**

- If applicable, indicate by provider number which service provider will the client obligation be assigned too. Depending upon the amount of the client obligation, a client obligation maybe divided between two providers.

**6. Signatures: Document**

- Parent/Guardian Signature must date and sign the Plan of Care, (all signatures must be legible).
- Autism Specialist must date and sign the Plan of Care (all signatures must be legible).

**Section V- Participant Signature Page**

- Anyone who has participated in the development of the IBP/POC must date and sign this page, and indicate what relationship they have with the child.

HCBS Autism Waiver  
Individualized Behavioral Program/Plan of Care

AW-004

Section I - Demographics

1. Date of IBP/POC 7/10/08

HCP/CSS Office Use Only  
Exception Date Rec'd: \_\_\_\_\_  
Initials: \_\_\_\_\_

Initial IBP   x   Revision   

Year 2    Year 3    Exception   

2. Child's Information

Name of Child Katrina Powell  
Medicaid Number: XXXXXXXXXXXX Social Security Number: xxx-xx-xxxx  
Street Address: 304 West St City: Tonganoxie  
County: Leavenworth State: KS Zip: 66086 Phone number: 913-417-7061  
Date of Birth: 12/25/03 Gender (circle one): M (F)

3. Parent / Legal Guardian Information

Name of Parent or Guardian: Edna and George Powell  
Street Address: 304 West St City: Tonganoxie  
County: Leavenworth State: KS Zip: 66086 Phone number: 913-417-7061  
X Natural / Adopted Parents    Foster Parents    Guardian    Child is in SRS Custody

4. Autism Specialist Information Provider No: \_\_\_\_\_

Name of Autism Specialist Provider: Susie Q  
Work Phone Number: 785-222-0000 Work Fax Number: 785-222-0001  
Work Street Address: Sugar Lane  
City: Somewhere County: Shawnee State: KS Zip: 66606  
Email Address: suie.q@sugarlane.com  
Independent Provider    Agency Provider   

\*\*\*\* Note: Complete section 5 if the Autism Specialist is employed by an agency.

5. Agency Information Agency No: \_\_\_\_\_

Name of Agency: IBT  
Work Phone Number: 785-222-0000 Work Fax Number: 785-222-0001  
Work Street Address: 304 West St.  
City: Tonganoxie County: Leavenworth State: KS Zip: 66086  
Type of Provider (choose the one that best describes your agency)  
  x   Developmental Disability    Mental Health    Child Welfare

6. Assessment Score & Diagnosis:

Date the Vineland II Adaptive Behavior Scales was completed 7/01/2008  
Mm/dd/yy

<b>VINELAND II ADAPTIVE BEHAVIOR SCALES</b>		
<b>Adaptive Areas:</b>	<b>Maladaptive Areas:</b>	<b>Diagnosis:</b>
Communication _____	Internalizing _____	<u>  </u> Autism <u>  </u>
Daily Living Skills _____	Externalizing _____	_____
Socialization _____	Total _____	
Motor skills _____		

\*\*Must have a total score or a score on any two elements of the Adaptive areas below the score of 70 or below **OR** a total score or a score on any two elements of the Adaptive area score 71-85 and the maladaptive score on the internal, external or total is 21-24

7. Criterion Reference Skilled Based Assessment

Name the type of Criterion Reference Skill Based Assessment utilized.

Assessment of Basic Language and Learning Skills (ABLLS)  
SRS/DBHS/CSS

4.14.2008



<b>Very Dissatisfied</b>	<b>Dissatisfied</b>	<b>Slightly Dissatisfied</b>	<b>Slightly Satisfied</b>	<b>Satisfied</b>	<b>Very Satisfied</b>	<b>N/A</b>
1	2	3	4	5	6	



Questions	Rating
15. My child's progress with his or her current educational services.	1
16. Our ability to balance our family's needs with my child's needs.	1
17. The ability of my child's current school or child care to address his or her individual needs.	1
18. The intensity of supervision my child needs.	1
19. My child's ability to do things for him/herself (ex. self-help skills, such as hand washing, toileting, sleeping, eating, etc.).	1
20. The frequency, severity, and/or intensity of my child's problem behavior.	1
21. My other children's feelings about my child (i.e. siblings).	2
22. My child's overall happiness and quality of life.	1
23. Others' perceptions of my parenting and disciplinary skills.	3
24. The extent to which the child's problem behavior affects the relationship between my significant other and me.	2
25. My ability to access support from professionals and/or network with other parents in similar situations.	3
26. My ability to cope with stress and other issues related to my child (i.e. emotional well being).	3

(modified from Behavior Impact Rating Tool 2007 ALT)

Please list the number of the preceding items that correspond to your 5 highest priorities.

1. 5
2. 13
3. 1
4. 8
5. 15

Please list the top 3 problem behaviors to address.

1. potty training
2. throwing things
3. eye contact

11. Global Risk Rating Scales: Consider the previous information and what you know about the child's entire behavioral repertoire. Use the rating scale below to indicate the child's overall risk levels.



Questions	Rating
1. The child's behavior is dangerous to others	3
2. The child's behavior provides a health risk to self (i.e., head banging, self-biting, etc.).	2
3. The child's behavior results in significant damage to property.	2.5
4. The child's behavior is likely to become serious in the future if not addressed.	5
5. The child's behavior is occurring at such a frequency or intensity that a caregiver's ability to effectively provide support is being compromised.	4
6. The child's behavior results in the involvement of law enforcement	1
7. The child's overall behavior puts them at risk of institutionalization or loss of a. current least restrictive environment, such as at home or at school.	4.5

## Section II - Domains

Section II addresses the following 12 life domains;

1. Behavior
2. Communication: Expressive
3. Communication: Nonverbal
4. Communication: Receptive
5. Community Readiness Skills
6. Concept Formation Skills
7. Family Environment
8. Imitation and Attending
9. Leisure/Recreation/Play
10. Motor Skills
11. Self-Help Skills
12. Social Interactions

### **Instructions:**

Each domain must be addressed, under each domain there are several sub-domains listed and at least one of those listed sub-domains must also be addressed. If there are more sub-domains to be included please use additional sheets as necessary. Additional sheets are included in the appendices.

Examples of how to complete the domains are in the Autism Policy & Procedure Manual in Section E (Assessment).

**A documented review of domains should be conducted by the Autism Specialist at least every 6 months.**

*Additional domain sheets are included in the Appendix 1.*

Child's Name:

# Sample

Date:

<b>Domain: Identify which life domains will be addressed</b>		<b>Goal #</b>
<b>Summary (with family input):</b> A general overview of the child's performance within this domains; specifically identify who reports and why, must include family input.		
<b>Strengths:</b>	<i>(Based on interview, observation, and assessment results, what skills does the child currently display?)</i>	
<b>Needs (linked to assessment results):</b>	<i>(Based on interview, observation, and assessment results, with which skills does the child currently need assistance?)</i>	
<b>Sub domains (Describe): Identify which sub-domain will be addressed, Autism Specialist must have a minimum of one per sub-domain</b>		
	<b>Description</b>	
<b>Sub Domain:</b>	Linked to Domain – must be specific, identify a specific skill set within the domain	
<b>Current Level of Performance:</b>	Describe in specific observable and measurable terms the child's behavior/skill level with the sub-domain.	
<b>Objective:</b>	Describe in specifics observable and measurable terms the goal with the sub-domain.	
<b>Child's Existing Supportive Skills:</b>	Skills that child currently exhibits that are the basic, core or related skills needed in order to address this objective.	
<b>Data Collection and Supportive Documentation:</b>	Method and measures that will be utilized to measure progress toward this objective. Collected data must include a minimum of one of following types: frequency, duration; intensity, or latency. Supportive documentation may include graphs, charts, and figures demonstrating progress.	
<b>Plan for Generalization:</b>	Describe how this skill will be taught and measured across multiple environments/settings and multiple people.	
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	Indicate the date (mm/dd/yyyy ) that revision or reviews were made. Document the change to the domain with notes.	
<b>Date Mastered and Next Steps:</b>	Indicate when the child has mastered the skill identified in the sub-domain and indentify what is the next task /skill the child will work on.	

Domain:	Behavior	Goal #
<b>Summary (with family input):</b> Katrina will follow instructions from adults when the proper reinforcement is available, but she often tries to obtain the reinforcing item by tantrumming if she is told to do something else first. When Katrina does not get what she wants or when she is unable to communicate her wants her needs, she will often resort to tantrumming behavior.		
<b>Strengths:</b>	Katrina knows several instructions and will often follow them when told. She has several caregivers and family members that are willing to implement behavioral strategies to help limit inappropriate behaviors and increase more appropriate and adaptive behaviors.	
<b>Needs (linked to assessment results):</b>	Katrina needs to be able to follow adult and peer instructions. She also needs to learn to disagree appropriately when told that she cannot have something or when she is unable to have something rather than engaging in tantrumming behaviors. Katrina also needs to learn how to communicate her needs to others in a more efficient and adaptive way.	
<b>Sub-domains (address a minimum of 1): Compliance, Challenging Behaviors, Stereotypic Behavior, Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>	Compliance with Instruction	
<b>Current Level of Performance:</b>	0-10%	
<b>Objective:</b>	Learner will comply with instructions from teachers and caregivers at home and in community settings.	
<b>Child's Existing Supportive Skills:</b>	Katrina has evidenced that she has the receptive language necessary to follow several simple and more complex instructions when there is proper reinforcement available.	
<b>Data Collection and Supportive Documentation:</b>	<p><b>Response Definition:</b> When given an instruction from teacher or parents, Learner will comply or begin to comply with the instruction within 5s.</p> <p><b>Teaching Procedure:</b> Throughout programs, teacher will intersperse simple one-step instructions throughout play and teaching. If learner complies within 5s, teacher will provide social reinforcement and contracted item. If learner does not comply within 5s, teacher will prompt compliance.</p> <p><b>Measurement Procedure:</b> Per opportunity recording. A + is recorded if learner complies with requests within 5s of the initial instruction. A – is recorded if learner does not comply within 5s. The level of prompt is recorded if the trial is prompted.</p>	
<b>Plan for Generalization:</b>	As learner meets mastery criteria, instructions will become more complex and parents will deliver instructions. Teacher will randomly assess maintenance of skill once a week for 4 weeks. If learner maintains 5/5 correct on all probes, maintenance	

	probes will drop to 1 per month for 6 months. If learner loses correct responses, teacher will reintroduce learning program until criteria is met.
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	As Katrina masters this program, introduce a delayed reinforcement schedule and imbed into all teaching programs

Domain:	Communication: Expressive	Goal #
<p><b>Summary (with family input):</b> Katrina is able to label several objects and colors and is able to ask for desired items by labeling them. When prompted, she is able to use a full sentence to request items. She sings songs and repeats lines from her favorite movies. Her mother would like Katrina to use her expressive communication for more than just requesting items.</p>		
<p><b>Strengths:</b></p>	<p>Katrina is able to say many words as evidenced by her repeating lines from movies, requesting, and singing; however, she has some difficulties with articulation. She also learns quickly when reinforcers are withheld for correct responding. She began using full sentences to request items without prompts after only 2 sessions of being prompted.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Katrina needs to be able label items on demand, label more adjectives, adverbs, and verbs, and improve her articulation when speaking and singing. Katrina also needs to lengthen her mean length of her responses and requests.</p>	
<p><b>Sub domains (address a minimum of 1): Requesting (Manding), Labeling (Tacts), Conversational Skills, Spontaneous Vocalizations, Syntax and Grammar, Information Recall and Initiations, Other (please specify)</b></p>		
	<p><b>Description</b></p>	
<p><b>Sub Domain:</b></p>	<p>Requesting with a full sentence</p>	
<p><b>Current Level of Performance:</b></p>	<p>Katrina currently asks for items using only the mand or the mand, please.</p>	
<p><b>Objective:</b></p>	<p>Katrina will independently make requests using a full sentence at least 80% of the time. (i.e. I want the toys please.”</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina quickly learns and discriminates what response is required to get desired reinforcers. She is able to use full sentences in contrived situations and can be prompted to do so.</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p><b>Teaching Procedure:</b></p> <ol style="list-style-type: none"> <li>1. Do a reinforcer assessment with Katrina.</li> <li>2. When a reinforcer is determined, prompt Katrina by saying, “Say want (item) please.”</li> <li>3. Katrina will repeat “Want (item) please.” <i>Data point</i></li> <li>4. If Katrina repeats the prompt within 3 seconds, then allow access to the reinforcer for 5-10 seconds.</li> <li>5. If Katrina fails to repeat the prompt within 3 seconds, restate the prompt.</li> <li>6. If Katrina fails to repeat the prompt after restating it. Engage in a behavioral momentum procedure and represent the prompt.</li> </ol> <p><b>Measurement procedure:</b> If Katrina repeats the prompt on the first try, then record the response as a + on the graph. If she responds on the second prompt, record it as a P+, and record as a – for non-compliance or other response. Record the number of independent requests that are full sentences and those that are not during sessions.</p>	

<b>Plan for Generalization:</b>	Have Katrina make requests in the community and with different people.
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	<p>Level 2:</p> <ol style="list-style-type: none"> <li>1. Do a reinforcer assessment with Katrina.</li> <li>2. When a reinforcer is determined, prompt Katrina by saying, "Say I want (item) please."</li> <li>3. Katrina will repeat "I Want (item) please." <i>Data point</i></li> <li>4. If Katrina repeats the prompt within 3 seconds, then allow access to the reinforcer for 5-10 seconds.</li> <li>5. If Katrina fails to repeat the prompt within 3 seconds, restate the prompt.</li> <li>6. If Katrina fails to repeat the prompt after restating it. Engage in a behavioral momentum procedure and represent the prompt.</li> </ol> <p><b>Measurement procedure</b></p> <p>If Katrina repeats the prompt on the first try, then record the response as a + on the graph. If she responds on the second prompt, record it as a P+, and record as a – for non-compliance or other response. Record the number of independent requests that are full sentences and those that are not during sessions.</p> <p>Level 3:</p> <ol style="list-style-type: none"> <li>1. Do a reinforcer assessment with Katrina.</li> <li>2. When a reinforcer is determined, prompt Katrina by saying, "Say I want the/my (item) please."</li> <li>3. Katrina will repeat "I Want the/my (item) please." <i>Data point</i></li> <li>4. If Katrina repeats the prompt within 3 seconds, then allow access to the reinforcer for 5-10 seconds.</li> <li>5. If Katrina fails to repeat the prompt within 3 seconds, restate the prompt.</li> <li>6. If Katrina fails to repeat the prompt after restating it. Engage in a behavioral momentum procedure and represent the prompt.</li> </ol> <p><b>Measurement procedure</b></p> <p>If Katrina repeats the prompt on the first try, then record the response as a + on the graph. If she responds on the second prompt, record it as a P+, and record as a – for non-compliance or other response. Record the number of independent requests that are full sentences and those that are not during sessions.</p>

Domain:	Communication: Nonverbal	Goal #
<p><b>Summary (with family input):</b> Katrina is able to communicate wants and needs by guiding a responsive adult to the object and pointing to it. She does not understand any hand gestures and rarely gives eye contact except when heavily prompted. She is more likely to give adults eye contact when a reinforcer is being withheld or in anticipation of a reinforcing activity. She is more likely to given eye contact to adults than peers or siblings.</p>		
<p><b>Strengths:</b></p>	<p>Katrina does give eye contact in anticipation of reinforcing activities and is able to use nonverbal to indicate things that she wants if she does not know how to ask verbally. There are several responsive adults that come into her home and they often make her give eye contact to obtain reinforcers.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Katrina needs to increase her eye contact with others and learn how to access the eyes and faces of others to obtain pertinent social information like emotion. Katrina needs to learn to differentiate between emotions both internally and in others. Katrina also needs to learn hand gestures that are often used in day to day life.</p>	
<p><b>Sub domains (address a minimum of 1): Emotions, Affect, Proximity, Reading Social Cues, Using Nonverbal Cues, Voice Intonation, Other (please specify)</b></p>		
	<p><b>Description</b></p>	
<p><b>Sub Domain:</b></p>	<p>Social referencing</p>	
<p><b>Current Level of Performance:</b></p>	<p>BL of 0%</p>	
<p><b>Objective:</b></p>	<p>Katrina will be able to look at another's face and access information about where to find something by following the eye gaze of another person.</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina will give eye contact in order to gain access to a reinforcing item and in anticipation of a reinforcing event.</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p><b>Teaching Procedure:</b>            1. Place a mini m&amp;m or other reinforcer under a plastic Easter egg            2. Present the direction, "Point to where I am looking".            3. Lift up the cup            If Katrina is correct, she gains access to the m&amp;m            If Katrina is incorrect, say, "Try again!"                If Katrina is incorrect, draw an imaginary line to the cup as needed            Data is a + for accurately following your gaze  <b>Measurement Procedure:</b> P+ = prompted response and is NOT included in % correct            A – is for non-compliance</p>	
<p><b>Plan for Generalization:</b></p>	<p>Katrina will accurately respond (80% of 10 trials) across 3 data days and 2 therapists</p>	

<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	When Katrina masters (80% across 3 data days and 2 therapists) one egg, increase it to 2 eggs, and then to 3 eggs. When she masters 3 eggs move her back 3 feet. When she masters this program after moving back, move to “I Spy.”

Domain:	Communication: Receptive	Goal #
<p><b>Summary (with family input):</b> Katrina appears to understand several labels and can follow several one and two step instructions. She also knows most of her shapes and colors. However, it was difficult to assess her receptive language due to non-compliance and the fact that she does not have skills of selection. Her family would like Katrina to learn more labels and be able to understand more novel instructions.</p>		
<p><b>Strengths:</b></p>	<p>Katrina knows several labels and can follow several one and two step directions. Her family is willing and able to spend the time to teach her new words and labels.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Katrina needs to learn how to make selections when directed to. She also needs to expand her repertoire of labels. She needs to learn adjectives other than colors and she needs to learn verbs as she seemed to only understand a couple of verb words. Katrina needs to learn how to follow more instructions, including novel and complex instructions.</p>	
<p><b>Sub domains (address a minimum of 1): Labeling (identifies nouns, objects, verbs), Follows Instructions (follows 1 step, 2 step, novel instructions), Other (please specify)</b></p>		
	<p><b>Description</b></p>	
<p><b>Sub Domain:</b></p>	<p>Selecting nouns, objects, adjectives, and verbs.</p>	
<p><b>Current Level of Performance:</b></p>	<p>Currently Katrina is not able to make selections from a set on objects or pictures.</p>	
<p><b>Objective:</b></p>	<p>Katrina will be able to select a pre-defined picture or object from a field of four pictures or objects. This will include at least 100 nouns, 20 actions, and 20 adjectives.</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina appears to have several labels and is able to acquire new labels quickly. This skill should be more evident once she acquires a selection skill.</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p><b>Teaching Procedure:</b>                      Presentation                      1. place an object on the table in front of Katrina                      2. say, "Hand me [object name]"                      3. Response: Katrina will hand you the object                      4. Remove the stimulus materials                      5. place the same object on the table in front of Katrina                      6. Present the Sd, "Point to [name of object]"                      7. Response: Katrina will point to the object                      8. Place the same object on the table in front of Katrina                      9.. Present the Sd, "Touch [name of object]"                      10. Response: Katrina will touch the object</p>	

	11. Remove the materials and represent <b>Measurement Procedure:</b> Data will be a + for a fully prompted response.
<b>Plan for Generalization:</b>	Different objects and picture cards will be introduced in different environments.
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	As Katrina masters each directive (e.g. touch, point to, hand me, give me, where is) place in discrimination with other mastered directives.  As Katrina masters each label, move to an expressive language program.

<b>Domain:</b>	<b>Communication: Readiness Skills</b>	<b>Goal #</b>
<p><b>Summary (with family input):</b> Katrina's family has discontinued many activities in the community that they had previously engaged in due to Katrina's behaviors of yelling, tantrumming, and refusal to wait or follow directions. The family would like to once again engage in these activities when she is more compliant.</p>		
<p><b>Strengths:</b></p>	<p>Katrina has evidenced an ability to follow several simple instructions. Her family is very on-board with using newly learned behavioral strategies to deal with her behaviors and help correct them.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Katrina needs to learn how to wait and listen for instructions. She also needs to be able to follow instructions, even less desirable ones, without the problem behaviors of screaming, crying, and throwing things.</p>	
<p><b>Sub domains (address a minimum of 1):</b> Waiting Skills, Following Routines, Group Instruction, Information Retention, Circle Time Skills, Activity Transitions, Other (please specify)</p>		
	<p><b>Description</b></p>	
<p><b>Sub Domain:</b></p>	<p>Waiting for instruction</p>	
<p><b>Current Level of Performance:</b></p>	<p>BL data is at 0</p>	
<p><b>Objective:</b></p>	<p>When given the instruction "wait", Katrina will sit with hands in lap (not touching materials) and appropriately "wait" until given another direction.</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina has evidenced an ability to follow several simple instructions. Her family is very on-board with using newly learned behavioral strategies to deal with her behaviors and help correct them.</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p><b>Teaching Procedure:</b> Begin teaching with no materials on table. Provide the instruction "wait" and prompt hands in lap. While learner sits, set materials on the table. Prompt learner to keep hands in lap, if necessary, using a physical (not a verbal) prompt. After materials are out, require specified time of waiting before reinforcing.  <b>Measurement Procedure:</b> Per opportunity measure. A + is recorded if learner does not attempt to touch materials until time requirement is met. A - is recorded if learner touches or attempts to touch materials before time requirement is met.</p>	
<p><b>Plan for Generalization:</b></p>	<p>Use the directive "wait" during dinner, when accessing reinforcers, at the play ground, with stimulus materials present, and during other routine activities</p>	
<p><b>Date Revised or</b></p>		

<b>Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	Begin requiring 1 second. After mastery criteria are met, increase number of seconds required to wait before reinforcement by 2s. Also, train with materials already present on table. As mastered, move to different levels

Domain:	Concept Formation Skills	Goal #
<p><b>Summary (with family input):</b> Katrina is currently unable to select items when given a direction to do so, so it was difficult to assess her concept formation skills. She is unable to match identical and non-identical pictures and objects, but can build with blocks on a picture card. She can play with a shape sorter and can do single-inset puzzles. She does appear to know some classes of objects (such as clothes and food). She know her colors and can count to 10 when a number line is present and an adult gets her started.</p>		
<p><b>Strengths:</b></p>	<p>Katrina has learned several visual performance tasks and does well with them when non-compliance does not get in the way.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Katrina needs to learn how to do other types of puzzles and how to match identical and non-identical pictures and objects. She needs to learn how to put objects into groups and how to do sequencing by following patterns, finishing patterns, and stories.</p>	
<p><b>Sub domains (address a minimum of 1): Matching, Sequencing, Puzzles, Patterns, Colors/Shapes/Size, Categories, Problem Solving, Preschool Skills (prepositions, colors, numbers, counting, computer skills), Other (please specify)</b></p>		
	<p><b>Description</b></p>	
<p><b>Sub Domain:</b></p>	<p>Matching objects and pictures.</p>	
<p><b>Current Level of Performance:</b></p>	<p>Currently Katrina is unable to match identical and non-identical objects and pictures.</p>	
<p><b>Objective:</b></p>	<p>Katrina will be able to match identical and non-identical objects and pictures based on label and adjectives such as color and size when presented with a field of four objects and one to match.</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina knows several labels including shapes, colors, and labels of objects. She has evidenced that she is able to scan an object and match other objects to parts of it (blocks to a picture card, shape-sorter, single inset type puzzles).</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p><b>Teaching Procedure:</b></p> <ol style="list-style-type: none"> <li>1. Place a picture on the table in front of Katrina.</li> <li>2. Present Katrina with an identical picture card with the SD, "Match."</li> <li>3. Katrina will place the picture presented on top of the picture in front of her.</li> </ol> <p><b>Measurement Procedure:</b> A + will be recorded if Katrina places the picture presented on top of the picture in front of her. A – will be recorded for non-compliance or placing the picture so that it is not touching the one in front of her.</p>	
<p><b>Plan for Generalization:</b></p>	<p>Use different objects and pictures in larger fields and teach rapid matching in a field of 10. Use identical and non-identical objects and pictures. Match pictures to objects and objects to pictures.</p>	
<p><b>Date Revised or Reviewed (at minimum each 6 months) and</b></p>		

<b>Notes:</b>	
<b>Date Mastered and Next Steps:</b>	Match pictures-to-pictures Move chair back to a distance of 10 feet with the directive “match” Move to “categories of objects” Move to “feature, function & class”

Domain:	Family Environment	Goal #
<b>Summary (with family input):</b> Katrina's family would like for her to interact more with the family and less time engaging in self-stimulatory behaviors like watching things spin.		
<b>Strengths:</b>	Katrina is able to recruit the attention of her parents to request desired items. She also exhibits sustained eye contact in anticipation of reinforcing events with parents, other adults, and siblings. She know how to play and enjoys participating in some social games with her family such as tag and ring around the rosie.	
<b>Needs (linked to assessment results):</b>	Katrina shows little to no interest in the behavior or her siblings. She rarely initiates interactions with her family members for social interaction, but rather only to gain access to tangibles or rubbing on her back.	
<b>Sub domains (address a minimum of 1): Schedule, Family Participation, Legal/Financial Considerations, Support Needs, Other (please specify)</b>		
	<b>Description</b>	
<b>Sub Domain:</b>	Increasing social initiations and interaction with others.	
<b>Current Level of Performance:</b>	Baseline data is needed.	
<b>Objective:</b>	Katrina will independently approach a family member or peer and initiate a social interaction at least ten times a day. This will not include requests for tangibles but will include conversations consisting of least three interchanges and asking others to play games with her.	
<b>Child's Existing Supportive Skills:</b>	Katrina knows how to play some social games including ring around the rosie and tag. Katrina can approach an individual and request desired items.	
<b>Data Collection and Supportive Documentation:</b>	<b>Teaching Procedure:</b> Level 1: <ol style="list-style-type: none"> <li>1. All "spinning" toys will be put in boxes and out of Katrina's reach.</li> <li>2. The provider will prompt Katrina by saying, "Say toys please."</li> <li>3. Katrina will repeat the prompt, "Toys please." <i>Data point graph 1</i></li> <li>4. Instruct Katrina to give a family member a hug, a high five, or play ring around the rosie with all persons present.</li> <li>5. Katrina will engage in the specified action with the specified person. She will begin the action within three seconds of the instruction. <i>Data point graph 2</i></li> </ol>	

<b>Plan for Generalization:</b>	Next level will be to teach other ways to interact (i.e. conversations and hand clapping games) and increasing the time she must spend interacting with a family member to obtain the toys.
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	<p>Level 2:</p> <ol style="list-style-type: none"> <li>1. All “spinning” toys will be put in boxes and out of Katrina’s reach.</li> <li>2. The provider will prompt Katrina by saying, “Say want toys please.”</li> <li>3. Katrina will repeat the prompt, “Want toys please.” <i>Data point graph 1</i></li> <li>4. Instruct Katrina to give a family member a hug, a high five, or play ring around the rosie with all persons present.</li> <li>5. Katrina will engage in the specified action with the specified person. She will begin the action within three seconds of the instruction. <i>Data point</i></li> </ol> <p>Level 3:</p> <ol style="list-style-type: none"> <li>1. All “spinning” toys will be put in boxes and out of Katrina’s reach.</li> <li>2. The provider will prompt Katrina by saying, “Say I want my toys please.”</li> <li>3. Katrina will repeat the prompt, “I want my toys please.” <i>Data point graph 1</i></li> <li>4. Instruct Katrina to give a family member a hug, a high five, or play ring around the rosie with all persons present.</li> <li>5. Katrina will engage in the specified action with the specified person. She will begin the action within three seconds of the instruction. <i>Data point graph 2</i></li> </ol> <p>If Katrina requests her toys without the prompt, but does not use the appropriate request (i.e. saying “toys” instead of “toys please”) then run all steps of the program (1-5). If she requests her toys appropriately without the prompt (saying “toys please”) then run steps 4 and 5 of the program.</p> <p>Track the number of times she independently requests toys.</p> <p><b>Measurement Procedure:</b> Per opportunity measure. A + is recorded on graph 1 if the learner repeats the prompt on the first try. A – is recorded on graph 1 if she does not answer or gives a response other than repeating the prompt. A + is recorded on graph 2 if she independently engages in the specified action with the specified person. A P+ is recorded for a prompted response. A – is recorded on the graph for non-compliance with the instruction, engaging in an action other than the one specified, or engaging in the action with a person other than the once specified.</p>

Domain:	Imitation and Attending	Goal #
<p><b>Summary (with family input):</b> Katrina is able to imitate others and often imitates dance moves and words from one of her favorite movies (Barney's Christmas Eve.) However, due to non-compliance, it was difficult to assess this skill since she did not readily imitate upon request. She does not readily imitate with objects. Rather than imitating, she plays with the object. She does not respond to her name.</p>		
<p><b>Strengths:</b></p>	<p>Katrina is able to chain together several complex movements as evidenced by her dancing with the movie. She is also able to imitate strings of words as evidenced by her scripting of movies; however, she has a difficult time with her intonation of words. This also shows her ability to attend as she learned these by watching and attending to the movie.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Katrina need to be able to engage in motor responses upon request as this will be an integral base skill for her ABA program. She also needs to be able to imitate with objects in order to learn how to appropriately play with toys rather than spinning them.</p>	
<p><b>Sub domains (address a minimum of 1): Responds to name, Gross Motor Movements, Fine Motor Movements, Movements with objects, Oral Motor Movements, Movements paired with sounds, Peer movements, Sequence of movements, Other (please specify)</b></p>		
	<p><b>Description</b></p>	
<p><b>Sub Domain:</b></p>	<p>Imitation with Objects</p>	
<p><b>Current Level of Performance:</b></p>	<p>Currently Katrina plays with objects when given an instruction to imitate.</p>	
<p><b>Objective:</b></p>	<p>Katrina will imitate a series of 10 activities and sounds with at least 3 different play sets.</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina is able to imitate, and once she has a home program in place with a focus on increasing compliance, then this skill should become more evident.</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p><b>Teaching Procedure:</b>            1. Move (hop/slide/twirl) an object to another object            2. Place one of the objects in/on the other            3. Move the two objects and add a vocalization, eg. Vroom, vroom. (present narration &amp; action simultaneously)            4. Hand Katrina the object and present the Sd, "You do it" <i>Data point for imitating the action and a Data point for imitating the vocal response</i>  <b>Measurement Procedure:</b> Run sequence 5 times for 10 points and record as % of opportunities with accurate imitation.</p>	
<p><b>Plan for Generalization:</b></p>	<p>Use different objects and have objects make different sounds. Once mastered, move this program to other areas of the house.</p>	
<p><b>Date Revised or</b></p>		

<b>Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	Next: chain together a sequence (10 play responses with vocalizations) Introduce back-and-forth Teach with new, age appropriate play sets

## Section II

Child's Name:

Date:

Domain	Leisure/Recreation/Play	Goal #
<p><b>Summary (with family input):</b> Katrina knows how to appropriately play with playground equipment outside and will engage in games of chase. She knows how to play the socially interactive game of Ring Around the Rosie. Katrina does not play with most toys appropriately as she tends to find small toys and she will make and watch them spin. Katrina's family would like to see her play with more toys appropriately and play interactively with others.</p>		
<p><b>Strengths:</b></p>	<p>Katrina enjoys playing the socially interactive game of Ring Around the Rosie and tries to get others to play it with her. She does know how to play with a shape sorter and inset puzzle appropriately as long as she does not choose to spin the pieces.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Katrina needs to learn how to engage with more toys appropriately and how to play more socially interactive games including board games and common games played in preschool such as Duck, Duck, Goose.</p>	
<p><b>Sub domains (address a minimum of 1): Independent Play, Imaginary Play, Block Play, Symbolic Play, Playing Games (board, socially interactive, computer based), Other (please specify)</b></p>		
	<p><b>Description</b></p>	
<p><b>Sub Domain:</b></p>	<p>Duck, Duck, Goose</p>	
<p><b>Current Level of Performance:</b></p>	<p>Katrina does not know how to play this game and tries to escape and play chase when prompted to sit in a circle.</p>	
<p><b>Objective:</b></p>	<p>Katrina will be able to play Duck, Duck, Goose with at least 2 other peers without having to be prompted through any of the steps.</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina is able to follow the direction to sit down. She also has experience playing social interaction games.</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p><b>Teaching Procedure:</b> Initially teach with stuffed animals.</p> <ol style="list-style-type: none"> <li>1. Sit in circle, <i>Data point</i></li> <li>2. Wait while person taps, <i>Data point</i></li> <li>3. Wait while other person runs. <i>Data point</i></li> </ol> <p>You're chosen:</p> <ol style="list-style-type: none"> <li>1. Sit in circle,</li> <li>2. Wait while person taps,</li> <li>3. Stand up and chase the other person around the circle,</li> <li>4. If you catch them, you sit back down; if you don't, you need to be "it".</li> </ol> <p>If you're "It":</p> <ol style="list-style-type: none"> <li>1. Walk around circle lightly tapping each circle member on the head</li> <li>2. Say "duck" while tapping each circle member on the head</li> </ol>	

	<p>3. Say “goose” on the person you want to run.  4. When you say “goose” take off running around the circle, until you get back to the empty seat.  5. Sit down and laugh.  <b>Measurement Procedure:</b> Initially just teach steps 1-3 so Katrina can learn to wait in the circle. Data point 1 will be a + for sitting down criss-cross. Data point 2 will be a + for independently waiting while remaining in the criss-cross position. Data point 3 will be a + for independently waiting while remaining in the criss-cross position. Data is a – for non-compliance.</p>
<b>Plan for Generalization:</b>	Move to other areas of the house and onto the community.
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	<p>Once all steps of the game are mastered, bring in siblings and other peers  Move to a typically developing preschool  Use during birthday parties</p>

Domain	Motor Skills	Goal #
<p><b>Summary (with family input): Katrina has good gross motor skills and can climb up onto almost anything. She is able to use her fine motor skills to play with pegs, blocks, and use clothespins, but she is unable to use a writing utensil for anything other than making marks on paper. She is currently unable to steer a tricycle, but her family is working on this with her. While Katrina has evidenced good gross motor skills, she will usually not engage in them upon request.</b></p>		
<p><b>Strengths:</b></p>	<p>Katrina has appropriate muscle development. She is also able to coordinate several gross motor movements as evidenced by her imitation of dance sequences from her favorite movie.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Katrina needs to learn how to use a writing utensil to draw letters, shapes, and numbers. She also needs to learn how to scissors to cut a line and shapes out of paper. She needs to learn how to color with crayons and markers.</p>	
<p><b>Sub domains (address a minimum of 1): Fine Motor, Gross Motor, Hand/eye Coordination, Other (please specify)</b></p>		
	<p><b>Description</b></p>	
<p><b>Sub Domain:</b></p>	<p>Coloring a picture</p>	
<p><b>Current Level of Performance:</b></p>	<p>Katrina does not currently know how to hold a crayon with an appropriate grip and does not color within boundaries of pictures. Currently, she will make marks on paper, but will not color.</p>	
<p><b>Objective:</b></p>	<p>When presented with a coloring page and some crayons, Katrina will independently color a picture with at least 3 colors and no more than 5 overlaps.</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina is able to make marks on a page.</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p>Teaching: Place glue lines on a piece of paper creating 9 squares per page 1. place the prepared paper on the table 2. using a crayon, model a back-and-forth coloring movement with 3 strokes of about 1 inch. 3. Hand the crayon to Katrina prompting it into the correct holding placement with the Sd, "you do it." Measurement: A + will be recorded for Katrina imitating the coloring motion making at least on back-and-forth stroke while staying in the square and using appropriate grip. A P+ will be recorded for a prompted response and will not be included in the overall percent correct. A – will be recorded for any other response or non-compliance.</p>	
<p><b>Plan for Generalization:</b></p>	<p>Different shapes and coloring pages will be used. Different colors and writing utensils will be implemented across different environments.</p>	
<p><b>Date Revised or Reviewed (at minimum</b></p>		

<b>each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	Remove glue lines Color with no more than 5 1 inch overlaps and at least 5 colors Color with a partner Color with a sibling Color with a peer Move to a writing program

Domain	Self- Help Skills	Goal #
<p><b>Summary (with family input):</b> Katrina is able to dress and undress herself, but does not do this without an adult prompting or helping her the whole way through. She can request food and feed herself using utensils and can drink out of a cup. She has to be prompted through most self-care activities. She was potty-trained for urine at one time, about 5 months prior to assessment according to Edna Powell, but she has regressed and is now using a pull-up for both urine and bowel movements. She has not used the toilet in several months.</p>		
<p><b>Strengths:</b></p>	<p>Katrina is able to engage in many self-help skills on her own and has been successful in potty training in the past. She has evidenced an ability to hold urine and bowel movements until she can get to a toilet. She has demonstrated, that with the proper reinforcement, she can independently engage in more self-help skills without prompts than she usually does.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Edna Powell expressed that her primary concern at this time is potty training because she fears that Katrina's regression in this area will affect her twin brother who also has autism. Katrina also seems to be moving forward in other areas of self-help, so her regression in this area is concerning.</p>	
<p><b>Sub domains (address a minimum of 1): Dressing/Undressing, Eating, Toilet Training, Health/Hygiene/Grooming, Independence/Self-monitoring, Other (please specify)</b></p>		
	<p><b>Description</b></p>	
<p><b>Sub Domain:</b></p>	<p>Potty Training</p>	
<p><b>Current Level of Performance:</b></p>	<p>Currently Katrina uses a pull-up. She does not use the toilet for urination or bowel movements.</p>	
<p><b>Objective:</b></p>	<p>Katrina will independently use the rest room as needed when he needs to urinate or have a bowel movement.</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina has been continent of urine before, therefore she has this skill set.</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p><b>Teaching Procedure:</b></p> <ol style="list-style-type: none"> <li>1. A teacher or caregiver will take Katrina to the toilet every fifteen minutes when she is awake and instruct her to sit.</li> <li>2. Check her pull-up to see if she is wet or dry. Record this on the data sheet. Reinforce a dry pull-up with a token and social praise. If she receives 5 tokens, she earns the terminal reinforcer.</li> <li>3. The timer will be set for 1 minute.</li> <li>4. If Katrina urinates or has a bowel movement in the toilet allow access to a specified reinforcer that is reserved only for using the toilet and social praise.</li> <li>5. When Katrina is dry for 3 days in a row, increase the time to 30 minutes. Continue to increase the time by 15 minutes every time she is dry for 3 days in a row.</li> </ol>	

	6. Record all bowel movements and determine the pattern for bowel movements to determine when to address toilet training for bowel.
<b>Plan for Generalization:</b>	Use toilets across environments.
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	Teach independent toileting

Domain	Social Interactions	Goal #
<p><b>Summary (with family input):</b> Katrina says hi and good-bye to familiar people when prompted to do so, and will often tell them good-bye when she wants them to leave. She will give eye contact in order to gain access to reinforcing items or in anticipation of reinforcing events. She does not currently initiate or maintain conversations. She does have limited relationship development with receptive adults and her siblings. For the most part, she only initiates social interactions to obtain reinforcing items and light touches which she finds reinforcing. She does not respond to her name when it is called.</p>		
<p><b>Strengths:</b></p>	<p>Katrina is able to greet others and say goodbye to others. She can playing socially interactive games and will share reinforcing activities (like bubbles) with others when the other individual initiates the activity.</p>	
<p><b>Needs (linked to assessment results):</b></p>	<p>Katrina needs to increase her eye contact during requesting without being prompted. She also needs to learn how to engage in conversations with others. She also needs to learn how to respond to her name when it is called with eye contact and a verbal response.</p>	
<p><b>Sub domains (address a minimum of 1): Joint Attention and Social Referencing, Eye Contact in Conversations, Adult Social Interactions, Complex Social Interactions, Initiating and Maintaining Conversations, Social Nuances, Relationship Development, Peer Social Interactions, Other (please specify)</b></p>		
		<p><b>Description</b></p>
<p><b>Sub Domain:</b></p>	<p>Responding to name</p>	
<p><b>Current Level of Performance:</b></p>	<p>Currently Katrina does not orient towards an individual or engage in a verbal response when her name is called.</p>	
<p><b>Objective:</b></p>	<p>Katrina will orient to an individual, give eye contact, and say, "What," when her name is called.</p>	
<p><b>Child's Existing Supportive Skills:</b></p>	<p>Katrina is able to give eye contact to obtain a reinforcer or when engaging in a reinforcing activity.</p>	
<p><b>Data Collection and Supportive Documentation:</b></p>	<p><b>Teaching Procedure:</b>            Initially start with a CR and no demand            1. Present the Sd "Katrina" while holding a reinforcing item next to your eyes.            2. Response: Katrina will make eye contact with the speaker within 3s.                If Katrina does not orient to the speaker within 3s, then draw her eyes to yours using the reinforcer and will be counted as a P+.  <b>Measurement Procedure:</b> A + will be recorded is Katrina independently makes eye contact with the speaker within 3 seconds. A P+ will be recorded for a prompted response and is not counted in the overall percent correct. A – is for non-compliance.</p>	
<p><b>Plan for Generalization:</b></p>	<p>Move the reinforcer further away from your eyes, begin to add saying "What," to the response. Start teaching when Katrina</p>	

	is not oriented towards you. Move around the house, school, and into the community and add additional people such as parents.
<b>Date Revised or Reviewed (at minimum each 6 months) and Notes:</b>	
<b>Date Mastered and Next Steps:</b>	<p>Introduce responding with “What?”</p> <p>Introduce responding with “what” from a distance of 20 feet within the same room (will require shaping)</p> <p>Introduce responding with “what” from a different room</p> <p>Introduce other adults calling name</p> <p>Introduce other children calling her name</p>

**Section III – Circle of Support**

**Emergency Contacts** - (In the event of an evacuation or scheduled staff is not available to work, who would be your emergency contact and/or back up plan to care for your child. Please list in order of priority.

1. Name	Address	Phone & Alternative Number	Relationship to child
Jill Wesley (Grandmother)	223 N. Fourth Tonganoxie, KS 66086	913-367-1362	8 am-2 pm
Nancy Heitzman		660-541-8379	2 pm-6 pm

**List the members of your household**

2. Name	Address	Phone & Alternative Number	Relationship to child
George Powell (Father)	304 West St Tonganoxie, KS 66086	913-367-0753	Variable
Edna Powell (Mother)	304 West St Tonganoxie, KS 66086	913-367-0753	Available before 9 am and after 5 pm on workdays (variable schedule, 3 days/week) Available all day on non-work days
Sky Powell (Sister)	304 West St Tonganoxie, KS 66086	913-367-0753	6 years old
George J. Powell, Jr. (Brother)	304 West St Tonganoxie, KS 66086	913-367-0753	4 years old
Katrina Powell (Client)	304 West St Tonganoxie, KS 66086	913-367-0753	4 years old

**Additional Non-Waiver Support /Services from Family, Friend, Neighbor, Church,**

3. Name	Relationship (check if primary caregiver)	Address	Phone	Service	Frequency	Paid	
						Yes	No
Debbie Groves	Aunt		660-541-8379	Babysitting	On Mother's work days	X	
Rita Boyles	Grandmother	223 N. Fourth Tonganoxie, KS 66086	913-367-1362	Babysitting	When Debbie cannot babysit		X

**HOME & COMMUNITY-BASED SERVICES FOR AUTISM SERVICES  
PLAN OF CARE**

**1. POC Approval Date** 7/10/08 (date the POC was approved on the MMIS by the Autism Program Manager)

**2. Child's name:** Katrina Powell **SS#:** xxx-xx-xxxx **Medicaid #:** xxxxxxxxxxx **DOB** 07/04/06

**Address:** 304 West St **City:** Tonganoxie **Zip:** 66086 **County** Leavenworth

**Identified Autism Specialist:** Susie Q **Provider Number:** xxxxxxxxxxx **Phone#** 785-222-0000 **Vineland II Assessment Date** 7/01/2008

**3. Plan of Care**

Waiver Services	Procedure Code	Provider Number	Provider Name	Units (15 min. = 1 unit)	Frequency	Total Units Monthly	Services Start Date	Services End Date	Discharge code	Cost Of Unit	Monthly Cost
IIS	H2019	100000000A		433	Monthly	433	07/10/2008	06/30/2009		6.25	2706.25
Res	T1005	100000000A		672	Yearly	56	7/10/2008	6/30/2009		3.00	168.00
FAC	S9482	100640840E		48	Yearly	4	7/10/2008	6/30/2009		10.00	40.00
										<b>Total Monthly Waiver Cost</b>	<b>2914.25</b>

**4. Client Obligation Amount if Applicable (assign to a specific provider)** \$ 00.00

**5. Assigned Provider(s) number.** \_\_\_\_\_ (1) \_\_\_\_\_ (2)

Release of Information: I consent to the release of the information on this page so my child can receive services. I understand the information included in this document will be release to Waiver Service Providers listed above to enable the delivery of services and program monitoring. I understand an electronic transmit of information such as a webcam maybe used as means to deliver services. My signature on this form also certifies that I agree to and helped develop this plan of care.

**6. Signatures**

_____	_____	_____	_____
Parent / Guardian Signature	Date	Autism Specialist	Date
_____	_____	_____	_____
Print Name	Relationship	Print Name	

\*\*\*\*Signature must be legible \*\*\*\*

**Section V – Participant Signature Page**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to child**

\_\_\_\_\_  
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**Print Name**

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**Signature**

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**Relationship to child**

\_\_\_\_\_  
**Date**

## Instructions for Parents/Guardian

Please complete the attached one page form to begin the process of applying for the Autism Waiver program.

### Step 1.

Section 1 requests basic information about your child and family. Personal information will be protected according to HIPPA guidelines. Please provide your child's name, date of birth, social security number (or SSN), your name as the parent or guardian, your address, a phone number by which you can be reached, and if applicable a Medicaid Identification Number.

### Step 2.

Section 2 includes two components. The first part requires you to indicate with a check mark which Autism screening tool was used in your child's diagnosis. Please check all that apply and if the screening tool is not listed, please specify which tool was used.

The second part is a check list of needed items to accompany this application. Please check next to "Documentation of Autism diagnosis is attached" if you have enclosed diagnosis documentation. Please check the "Signature of licensed Medical Doctor or Ph.D. Psychologists" if a Medical Doctor or Ph.D. Psychologist has read, signed and dated the statement provided at the bottom of section 2.

### Step 3.

**The form must be completed in its entirety to be eligible.**

**The fully completed application can be submitted three ways.**

1. Faxed to CSS, at 785-296-0557,
2. Hand delivered to your local SRS office to be time/date stamped and faxed to CSS, or
3. Mailed to Docking State Office Building

Attention: Community Supports & Services  
915 SW Harrison, 9th Floor  
Topeka, KS 66612

## What Happens Next?

If a child meets the criteria for the HCBS Autism Waiver, the child will receive a letter from the Autism Program Manager informing them they have been placed on the Proposed Waiver Recipient List and their numerical position on the list. When a position on the waiver becomes available the Program Manager will contact the family to offer them the potential position.

Once a child has been referred by the Program Manager for assessment, the Functional Eligibility Specialist has 5 working days to schedule a home visit and complete the functional eligibility assessment to determine if the child meets the established criteria. If the child meets the criteria, the Functional Eligibility Specialist will assist the family in completing the Medicaid application (if necessary) and refer to an Autism Specialist.

The Autism Specialist has 5 working days to contact the family to begin the development of the Individualized Behavioral Plan/Plan of Care.

\*\*\*PLEASE NOTE: SRS Regional Office must affix time/date stamp immediately upon receipt.\*\*\*

## Home and Community Based Services Autism Waiver

The form must be completed in its entirety to be eligible.  
The fully completed application can be submitted three ways.

1. Faxed to CSS, at 785-296-0557,
2. Hand delivered to a local SRS office to be time/date stamped and faxed to CSS, or
3. Mailed to Docking State Office Building  
Attention: Community Supports & Services  
915 SW Harrison, 9th Floor  
Topeka, KS 66612

### SECTION 1: CHILD AND FAMILY INFORMATION

Please provide the following information:

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Child's SSN: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Medicaid ID Number (if applicable): \_\_\_\_\_

### SECTION 2: AUTISM SPECTRUM DISORDER INFORMATION

Diagnosis was made with the aid of the following approved Autism screening tool:

- CARS Childhood Autism Rating Scale
- GARS Gilliam Autism Rating Scale
- ADOS Autism Diagnostic Observation Scale
- ADI Autism Diagnostic Interview-Revised
- ASDS Asperger Syndrome Diagnostic Scale
- Other Please Specify \_\_\_\_\_

Documentation of Autism diagnosis or a signature of a licensed Medical Doctor or Ph.D. Psychologist must be included at the time the application is submitted.

Please indicate with a check mark if any or all of the following is included with this application:

Documentation of Autism diagnosis is attached.

Signature of licensed Medical Doctor or Ph.D. Psychologists

*Documentation will be required at the time of eligibility determination.*

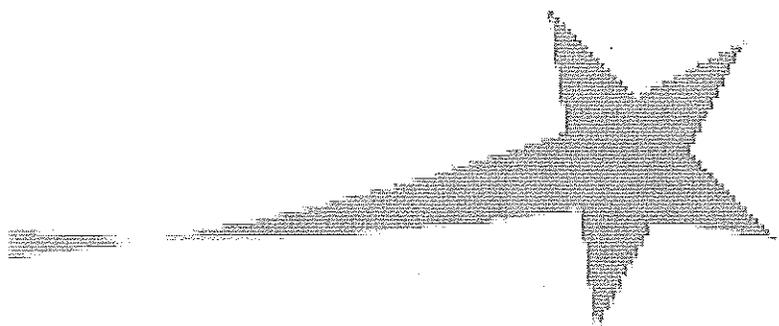
I have made a diagnosis of an Autism Spectrum Disorder for \_\_\_\_\_.

Enter Child's Name

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Printed Name of Doctor

\_\_\_\_\_  
Date



# **Servicios Basados en el Hogar y la Comunidad Exención por Autismo**

Paquete de Información para el Cliente



## ¿Cuál es el Programa de Exención por Autismo Basado en el Hogar y la Comunidad?

- La Exención por Autismo está diseñada para proporcionar los servicios de intervención intensiva temprana a los niños con Trastornos del Espectro de Autismo (ASD por sus siglas en inglés).
- Los niños son elegibles para ingresar al programa desde la edad en la que son diagnosticados hasta la edad de cinco años.
- Un niño será elegible para recibir los servicios de exención durante un período de tres años.
- Para ser elegible para los servicios de Exención por Autismo el niño debe recibir un diagnóstico de ASD de parte de un Médico o Psicólogo Doctorado Licenciado.
- Cuando se ofrece un puesto a un niño en la Exención por Autismo de los Servicios Basados en el Hogar y la Comunidad (HCBS), los administradores del programa luego derivarán a la familia al Especialista en Elegibilidad Funcional para que sea evaluada para una Determinación de Nivel de Cuidados para establecer la elegibilidad funcional para los servicios de Exención. La Encuesta Entrevista Vineland II de Escalas de Conducta Adaptativa será una herramienta utilizada para la evaluación.
- Para ser elegible para los servicios, el niño debe recibir un diagnóstico de ASD, cumplir con los requisitos de elegibilidad funcional (nivel de cuidados), y satisfacer la prueba de medios financieros para la elegibilidad para Medicaid.
- Una vez que la elegibilidad funcional ha sido establecida, el Especialista en Elegibilidad Funcional ayudará a la familia a completar la solicitud para Medicaid (si fuera necesario) y derivará a la familia al Especialista en Autismo que la familia elija. Este especialista trabajará con la familia para desarrollar un plan de cuidados e identificar proveedores de servicios.
- Resumen de los servicios de Exención:
  - Cuidado de Alivio: El Cuidado de Alivio proporciona cuidado directo temporal y supervisión para el niño para proporcionar alivio a las familias/prestadores de cuidado de un niño con un ASD.
  - Apoyo y Entrenamiento para Padres: El Apoyo y Entrenamiento para Padres está diseñado para proporcionar el entrenamiento y apoyo necesario para asegurar el compromiso y la participación activa de la familia en el proceso de tratamiento y con la implementación y refuerzo permanente de las habilidades aprendidas durante el Proceso de tratamiento.
  - Apoyos Individuales Intensivos: Servicios proporcionados a un niño con un ASD diseñados para ayudar a adquirir, retener, mejorar, y a generalizar las habilidades de auto ayuda, socialización, y adaptación necesarias para residir y funcionar en forma exitosa en el entorno del hogar y la comunidad.
  - Servicios Consultivos Clínicos y Terapéuticos: Servicios proporcionados por un Especialista en Autismo para ayudar a la familia y al personal de apoyo u otros profesionales pagos a llevar a cabo el programa individual que respalda el desarrollo funcional del niño y su inclusión en la comunidad.
  - Asesoramiento de Adaptación Familiar: Asesoramiento proporcionado a los miembros de la familia de un niño con un ASD para ayudarles a sobrellevar la enfermedad del niño y el estrés relacionado que acompaña a la comprensión inicial del diagnóstico y el cuidado diario, continuo y permanente requerido por el niño con ASD.
- Las solicitudes de Exención por Autismo estarán disponibles a partir de Diciembre de 2007 en las siguientes ubicaciones;
  - Oficinas del SRS,
  - Centros Comunitarios de Salud Mental,
  - Organizaciones Comunitarias de Discapacidades del Desarrollo,
  - Proveedores de Servicios Comunitarios,
  - Contratistas de Cuidado Sustituto,
  - Families Together,
  - Keys for Networking, y
  - [www.srskansas.org](http://www.srskansas.org).

## Instrucciones para Padres/Tutores

Por favor complete el formulario adjunto de una página para iniciar el proceso de solicitud del programa de Exención por Autismo.

### Paso 1.

La sección 1 solicita información básica acerca de su niño y su familia. La información personal estará protegida de acuerdo con las pautas de la Ley de Movilidad y Responsabilidad del Seguro de Salud (HIPAA por sus siglas en inglés). Por favor proporcione el nombre de su niño, la fecha de nacimiento, número de seguro social (o SSN por sus siglas en inglés), su nombre como padre o tutor, su domicilio, un número de teléfono donde usted pueda ser localizado, y si Aplica un Número de Identificación de Medicaid.

### Paso 2.

La sección 2 incluye dos componentes. La primera parte requiere que usted indique con una marca qué herramienta de observación de Autismo fue utilizada en el diagnóstico de su niño. Por favor marque todas las que apliquen y si no se encuentra listada la herramienta de observación, por favor especifique qué herramienta fue utilizada. La segunda parte es una lista de control de los artículos necesarios para que acompañen esta solicitud. Por favor marque al lado de "se adjunta Documentación del diagnóstico de Autismo" si usted ha adjuntado la documentación del diagnóstico. Por favor marque la "Firma de un Médico o Psicólogo Doctorado licenciado" si un Médico o Psicólogo Doctorado licenciado ha leído, firmado y fechado la declaración proporcionada al final de la sección 2.

### Paso 3.

**El formulario debe ser completado en su totalidad para ser elegible.**

**La solicitud totalmente completada puede ser presentada de tres maneras.**

1. Enviada por fax a los Servicios y Apoyo Comunitarios (CSS por sus siglas en inglés) al teléfono 785-296-0557,
2. Entregada en mano en su oficina local del SRS para ser estampillada con fecha y hora y enviada por fax al CSS, o
3. Enviada por correo a Docking State Office Building  
Attention: Community Supports & Services  
915 SW Harrison, 9th Floor  
Topeka, KS 66612

## ¿Qué Sucede Después?

Si el niño cumple con los criterios para la Exención por Autismo del HCBS, el niño recibirá una carta del Administrador del Programa de Autismo informándoles que han sido colocados en la Lista de Receptores de la Exención Propuesta y su posición numérica en la lista. Cuando pasa a estar disponible un lugar en la exención el Administrador del Programa se comunicará con la familia para ofrecerles el lugar potencial.

Una vez que el niño ha sido derivado por el Administrador del Programa para su evaluación, el Especialista en Elegibilidad Funcional tiene 5 días hábiles para programar una visita al hogar y completar la evaluación de elegibilidad funcional para determinar si el niño cumple con los criterios establecidos. Si el niño cumple con los criterios, el Especialista en Elegibilidad Funcional ayudará a la familia a completar la solicitud para Medicaid (si fuera necesario) y lo derivará a un Especialista en Autismo.

El Especialista en Autismo tiene 5 días hábiles para comunicarse con la familia para comenzar a desarrollar el Plan Individualizado de Conducta/Plan de Cuidados.

\*\*\*PLEASE NOTE: SRS Regional Office must affix time/date stamp immediately upon receipt.\*\*\*

## Servicios Basados en el Hogar y la Comunidad Exención por Autismo

El formulario debe ser completado en su totalidad para ser elegible.

La solicitud totalmente completada puede ser presentada de tres maneras.

1. Enviada por fax al CSS, al teléfono 785-296-0557,
2. Entregada en mano en una oficina local del SRS para ser estampillada con fecha y hora y enviada por fax al CSS, o
3. Enviada por correo a Docking State Office Building  
Attention: Community Supports & Services  
915 SW Harrison, 9th Floor  
Topeka, KS 66612

### SECCION 1: INFORMACIÓN ACERCA DEL NIÑO Y LA FAMILIA

Por favor proporcione la siguiente información:

Nombre del Niño: \_\_\_\_\_

Fecha de Nacimiento del Niño: \_\_\_\_\_

Numero de Seguro Social del Niño (SSN): \_\_\_\_\_

Padre/Tutor: \_\_\_\_\_

Domicilio: \_\_\_\_\_

Número de Teléfono: \_\_\_\_\_

Número de Identificación de Medicaid (si fuera aplicable): \_\_\_\_\_

### SECCION 2: INFORMACIÓN ACERCA DEL TRASTORNO DEL ESPECTRO DE AUTISMO

El diagnóstico fue realizado con la ayuda de la siguiente herramienta de observación de Autismo aprobada:

- CARS Escala de Valoración del Autismo en la Niñez (CARS por sus siglas en inglés)
- GARS Escala de Valoración de Autismo Gilliam (GARS por sus siglas en inglés)
- ADOS Escala de Observación Diagnóstica de Autismo (ADOS por sus siglas en inglés)
- ADI Entrevista Diagnóstica del Autismo (ADI por sus siglas en inglés) - Revisada
- ASDS Escala de Diagnóstico del Síndrome de Asperger (ASDS por sus siglas en inglés)
- Otro Por favor Especifique \_\_\_\_\_

Se debe incluir la documentación del diagnóstico de Autismo o la Firma de un Médico o Psicólogo Doctorado licenciado en el momento en que la solicitud es presentada.

Por favor indique con una marca si alguna o todas las siguientes son incluidas con esta solicitud:

- Se adjunta documentación del diagnóstico de Autismo.
- Firma de un Médico o Psicólogo Doctorado licenciado.

La documentación será requerida al momento de la determinación de elegibilidad.

#### Sólo para el uso del Médico

I have made a diagnosis of an Autism Spectrum Disorder for \_\_\_\_\_

Enter Child's Name

Signature of Doctor

Printed Name of Doctor

Date



# Parent Fee Program Manual



915 SW Harrison  
Docking State Office Building, 9 Floor West  
Topeka, Kansas 66612  
(785) 296-3536

<http://pubauth.srs.ks.gov/agency/css/pfp/Pages/Default.aspx>

Revised February 2010

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- Part II** – Overview of Parent Fee Program
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- Part IV** – General Program Administration Information
- Part V** – Fee Variance – “Hardships” or “Significant Changes” in Circumstances
- Part VI** – Appeals and Fair Hearings
- Part VII** – Collection Process
- Appendices:** Legislative Proviso – June 2002  
IDF – Information Disclosure Form  
RFV – Request for Fee Variance Form

## **ABBREVIATIONS USED IN THIS MANUAL**

AGI	Adjusted Gross Income (per Federal Income Tax Form)
CDDO	Community Developmental Disability Organization
CMHC	Community Mental Health Center
DBHS	Disability and Behavioral Health Services (one of four Divisions within SRS)
DD	Developmental Disability (includes Mental Retardation)
FPL	Federal Poverty Level
HCBS	Home and Community Based Services (an SRS program resulting from a Waiver to the federal regulations governing the Social Security Act)
IDF	Information Disclosure Form
MO	Management Operations (one of the Sections within DBHS)
PD	Physical Disability
RFV	Request for Fee Variance Form
SDSO	State Debt Set Off
SED	Serious Emotional Disturbance
SRS	The Kansas Department of Social and Rehabilitation Services
TA	Technology Assistance
TBI	Traumatic Brain Injury
Waiver	Also referred to as HCBS

## **PART I – PARENT FEE PROGRAM BACKGROUND**

In the Spring of 2002, the Kansas Legislature directed the Kansas Department of Social and Rehabilitation Services (SRS) to start charging and collecting fees from parents to pay for a portion of the Home and Community Based Services (HCBS) provided to their children.

Affected by this legislation are biological parents with minor children living in their home, who receive services through one of the HCBS Waivers. The concept of *cost-sharing* underlies the legislation whereby parents who have the financial means, share in the cost of providing services to their minor children.

SRS and a stakeholder group wanted to keep the Parent Fee Program simple and streamlined. As a result, the Parent Fees are set on a specific income figure for a past time period (as reported on the most recent federal tax return).

In addition, a sliding parent fee schedule was developed with the assistance of the stakeholder group.

The policies and procedures in this Manual are designed to administer the Parent Fee Program and to inform parents and other interested individuals about the Program. Questions may be directed to:

SRS, Disability and Behavioral Health Services - Parent Fee Program  
Docking State Office Building, 9<sup>th</sup> Floor West  
915 SW Harrison  
Topeka, KS 66612-1570

Phone: (785) 296-3536

Fax: (785) 368-6228

E-Mail: [ParentFee@srs.ks.gov](mailto:ParentFee@srs.ks.gov)

## **PART II - OVERVIEW OF PARENT FEE PROGRAM**

HCBS Waiver programs included in the Parent Fee Program:

- Autism
- Developmental Disability (includes Mental Retardation)
- Physical Disability
- Serious Emotional Disturbance
- Technology Assistance
- Traumatic Brain Injury

Eligibility for a Home and Community Based Services (HCBS) Waiver Program for a child is determined without considering parental resources or income.

Parents of children who receive services through a Waiver Program listed above are provided an Information Disclosure Form (IDF) to complete and return to SRS.

Parent's income, family size and related information provided on the IDF is used to set the family fee.

Parents are invoiced monthly around the fifteenth (15<sup>th</sup>) of the month.

Payments are due by the eighth (8<sup>th</sup>) day of the following month.

Parents mail checks payable to "State of Kansas - SRS" with the bottom portion of the Invoice to SRS.

Fee variances due to a hardship or to significantly changed circumstances may be requested (See Part V).

Parents may appeal the decision or final action of SRS by requesting a Fair Hearing from the Kansas Department of Administration, Office of Administrative Hearings (see Part VI).

Community Mental Health Centers, Community Developmental Disability Organizations or their affiliate providers, SRS or an agency contracted by SRS, may briefly explain the Parent Fee Program and provide parents Parent Fee Program materials or forms.

The rules governing the Parent Fee Program are explained in this Manual and are available on the internet at <http://pubauth.srs.ks.gov/agency/css/pfp/Pages/Default.aspx>

## **PART III –PARENT FEE RESPONSIBILITY AND FEE DETERMINATION**

### **A. Rules Governing Parent Fee Payment Responsibility**

1. Biological parents who live in the same household as the child receiving services are charged a fee.
2. A divorced parent living elsewhere is not charged a fee.
3. When a child with divorced parents lives in both parents' households (joint custody), the parent who claims or is entitled to claim the child as an exemption on their federal income tax form is charged the fee for the following year.
4. Foster parents of a child receiving services through the waiver, adoptive parents, and grandparents or other relatives rearing the child are not charged a parent fee.

### **B. Rules Governing Income**

1. Income is determined retroactively, based on the most recent federal income tax return of the parent(s) responsible for the fee. The fee is based on household income, not assets.
2. Income is defined as the Adjusted Gross Income (AGI) of the parent(s) and any other income earners who are both claimed as an exemption and whose income is included on the most recent federal tax return.
3. Types of income included:
  - a. Income of a stepparent who lives with the parent and child and files federal taxes jointly with the biological parent.
  - b. Income of both parents who reside in the household and filed federal income tax separately.
  - c. Income of a person(s) age 18 or above living in the household, regardless of whether the person(s) are related by blood or marriage to the biological parent or the child, and whose income is included on a jointly filed income tax return that includes at least one biological parent.
4. Types of income excluded:
  - b. Income of a divorced parent living elsewhere.
  - c. Income of a biological parent living in a separate household, whether married or separated.

- d. Income of others living in the household, who file separately from the parent(s) and who are not claimed as an exemption on the parents' return.
  - e. Income of a high school or college student in the household, if the student is claimed as an exemption on the parents' federal tax return.
5. If there is **no** federal tax return, then income that is most like the "Adjusted Gross Income" figure that would have appeared on the parents' tax return is to be estimated.
  6. If there is a significant difference, higher or lower (typically +/- 20%), between the AGI on the last year's tax return and the estimated AGI figure for the current tax year, a brief explanation/reasons for the variation may be provided to SRS for consideration in determining the monthly fee.

### **C. Rules Governing Household Size Determination**

1. Household size is the number of individuals residing in the household with the child and claimed as exemptions on the most recently filed federal tax return(s) of the parent(s).
2. Family size will be based on both income tax returns, if both parents reside in the same household and have filed separately.
3. If there is **no** federal tax return, then the number of exemptions that would have been claimed as outlined in #1 and #2 on a tax return is to be estimated.
4. If the household size differs between the last year's tax return and the estimation for the current tax year, a brief explanation of the reason for the difference must be provided to SRS for consideration in determining the monthly fee.

### **D. Process for Determining the Amount of the Monthly Parent Fee**

1. Parents are to complete and submit the "Information Disclosure Form" (IDF) to DBHS/Parent Fee Program within 20 calendar days of receiving the form from SRS, a CMHC, a CDDO or an affiliate provider, or an agency contracted by SRS. The IDF form may be provided to the parent in person, by mail, fax, e-mail, or similar means.
  - a. Attachments requested on the IDF should accompany the submission of the IDF.
  - b. DBHS may require additional information to explain, support, or update information on the IDF.

- c. Failure to fully complete the IDF and/or failure to return the completed IDF to DBHS within 30 days of the provision of the form will result in a default fee of \$200 per month being assessed.
  2. The Parent Fee will be determined by DBHS using the rules in this Manual.
    - a. Income and family size will be determined according to Section B & C above.
    - b. DBHS will not charge a parent more than one Parent Fee even if two or more children are receiving services from applicable SRS Programs. DBHS will determine if the Parent is already paying a Parent Fee for a child in another SRS HCBS Program.

DBHS will send written notice to the parent about the fee set. This notice may be included in the envelope with the first monthly invoice.

- a. Failure to update income information may result in a default fee of \$200 per month from the date updated information is requested.
  3. The fee is in effect for a period of at least one year and updated annually based on the most recent year's AGI in the month of the child's birthday unless the child ceases to receive HCBS services or reaches the age of 18.
  4. DBHS will consider fee variance requests received from the parents per Part V.

#### **Part IV – GENERAL PROGRAM ADMINISTRATION INFORMATION**

The parent fee is effective the first full month the child is enrolled in the HCBS Waiver program and each enrolled month thereafter.

The parent fee is owed for the month a child exits the program. (Medicaid cards expire on the last day of the month, so the child is considered enrolled for the complete month.)

- When the child discontinues receiving HCBS services, parents are to notify SRS by indicating the date of service discontinuation in writing.
- When a child reaches the age of eighteen (18), parents are to notify SRS in writing. The parent fee is owed for the month in which the child reaches the age of eighteen (18).

After a child discontinues HCBS services or reaches the age of 18, outstanding balances are still due.

Parents who fall in behind on their payments are encouraged to contact SRS – Disability and Behavioral Health Services – Parent Fee Program at 785.296.3536 to work out a payment plan that will pay off the debt in a reasonable period of time.

SRS is authorized to pursue collection of unpaid balances, including pursuing payment through legal action, if necessary (see Part VII). However, the child will not be removed from HCBS waiver services due to non-payment.

DBHS will consider whether the total amount parents paid during the state fiscal year (July 1 - June 30) was in excess of the actual cost incurred in providing services during the fiscal year. If the total amount of fees paid by the parents exceeds the total cost of services (both HCBS Waiver services and services paid for by the Kansas Health Policy Authority-issued Medical Card), then DBHS will return the excess amount within 30 days of its discovery or credit it to the parent's account.

## **PART V – FEE VARIANCE -- “HARDSHIPS” OR “SIGNIFICANT CHANGES” IN CIRCUMSTANCES THAT WARRANT A CHANGE IN FEE**

The stakeholder group that assisted with the establishment of the sliding parent fee schedule discussed many circumstances that create expenses for families who have a child with a disability; the final fee table that was adopted accounts for many of those situations. It is anticipated that fee reductions would be uncommon and only for “significant changes.”

The Legislative Proviso that established the parent fees collection program indicated that fees are to be waived “for families below 200% of the federal poverty level” and “in cases of demonstrable hardship.” These are the only circumstances under which fees are waived.

A Fee Variance means any modification of the parent fee from that indicated by the Parent Fee Schedule, due either to a hardship or to significantly changed circumstances. A variance may result in a reduction in or waiver of the fee. Fee reductions or waivers may be for short or long terms depending upon the circumstances.

Examples of a significant change in circumstances include, but are not limited to: an increase in family size due to the birth of a child; loss of a job; or an income drop of 20% or more.

Examples of hardships include, but are not limited to; homelessness; loss of income that drops the family income to less than 200% of the FPL; high health care costs not covered by insurance; or costly damage to home or property not covered by insurance.

The purchase of a new home or a family member attending college are the more usual or typical situations that do not qualify as circumstances for hardship consideration.

Please note that SRS will require a Request for Fee Variance (RFV) form and updated information on income and family size be provided in order to consider a fee variance request.

### **A. Criteria for Consideration of a Fee Variance**

1. Listed below is the information needed for consideration of a fee variance. (This list may not be all inclusive.)
  - a. What is the significant change in circumstances, or hardship?
  - b. What are the consequences and impact of the resulting financial burden?
  - c. Is there a significant burden being placed on the family of a non-financial nature?
  - d. Is the family’s response to the burden a result of events beyond the family’s control or partly the result of its own choosing?

- e. How does the situation create expenses for the family above the usual circumstances for families who have a child with a disability?
- f. Is the family experiencing deprivation of essential needs like food, clothing or shelter?
- g. How long is the deprivation or burden likely to continue?
- h. An estimate of Adjusted Gross Income (AGI) for the current tax year, a copy of first page of the prior year's Federal Income Tax return and a brief explanation of the reason for the variation. If a severance package is to be received as part of a layoff, the income from it is to be included in the AGI.
- i. Additional information parents want SRS to consider that is not included in above listed items.

## **B. Process to Request a Fee Variance**

1. Parents may request a variance at any time by making a written request using the Request for Fee Variance (RFV) form provided at the end of this Manual.
2. Within 12 business days of receipt of the RFV, DBHS may ask for additional information to fully consider the family's situation. Information requested will assist DBHS in determining if the request is reasonable and fair to other participating parents.
3. DBHS will render a decision on all Requests for Fee Variance within 45 calendar days of receipt. Parents will be notified in writing of the decision. Specific terms of variance approvals will be included in the written notification. Parents may contact DBHS with any questions or to discuss the rationale for the decision.
4. The variance may be limited to a specified number of months and/or require the parents to notify DBHS when the primary reason for the variance is resolved. For example, parents who are laid off will be required to notify DBHS when they become employed again.
5. The decision of SRS may be appealed under the procedures of the Kansas Department of Administration, Office of Administrative Hearings. (See Part VI)

## **C. Payment Responsibilities Pending a Determination for Fee Variance**

1. Parents requesting a fee variance at the time they submit their initial IDF are not required to make a payment pending the determination.
2. Parents currently being invoiced are to continue making payments during the time a Request of Fee Variance (RFV) is being considered.

3. If payments made pending a Fee Variance determination result in an overpayment to SRS, the overpayment may be refunded or applied to future monthly fees owed by the parents.
4. If payments received pending a Fee Variance determination result in an underpayment to SRS, then parents are to pay the amount due within 15 days of notice of the SRS determination.

## **PART VI - APPEALS AND FAIR HEARINGS**

A person may appeal the decision or final action of SRS by requesting a Fair Hearing from the Kansas Department of Administration, Office of Administrative Hearings. This Office is not a part of the Department of SRS. Requests for a Fair Hearing must be in writing and received by the Office of Administrative Hearings or SRS within 33 calendar days from the mailing date of the SRS notice of its decision (or 30 days if the denial was delivered to the parent on the date of the notice). The Kansas Department of Administration, Office of Administrative Hearings, may be contacted as follows:

Kansas Department of Administration  
Office of Administrative Hearings  
1020 S. Kansas Ave  
Topeka, Kansas 66612

Phone: (785) 296-2433  
Fax: (785) 296-4848

Fair Hearings processes are governed according to the rules, time lines, and procedures of the Office of Administrative Hearings. Additional information or fair hearing request forms may be obtained on-line at <http://da.state.ks.us/hearings/request.htm>. You may have legal counsel or others to represent you at the hearing. If you are dissatisfied with the hearing decision, you may request a review of the decision by the State Appeals Committee. The decision of the State Appeals Committee may be appealed to the district court.

## **PART VII - COLLECTION PROCESS**

1. Parents unable to pay their fees by the due date are encouraged to contact DBHS at (785) 296-3536 to discuss entering into a Payment Agreement and to see if their fees may be paid in whole or part by the State Debt Set Off process described in #3 below.
2. Parents who either do not pay their fees or otherwise do not cooperate with the rules of the Parent Fee Program are subject to SRS's collection process.

(**NOTE:** During the time a child is receiving HCBS services, if parents fail to pay the fees, SRS will not deny HCBS services to the child, but SRS is authorized to pursue collection of the delinquent balance due, including pursuing payment through legal action, if necessary. SRS is also authorized to pursue any balance due after a child is no longer receiving services.)

3. When a parent has received at least three monthly billing invoices and is twenty-five dollars (\$25.00) or more overdue, SRS may submit a notice to the State Debt Set-off (SDSO) Section, which is not a part of SRS. SDSO will intercept any State payment due the parent. This may include the following types of payments: tax refunds; lottery winnings; contract payments; salary; wages; KPERS lump-sum withdrawals; and travel reimbursements. Money collected by the SDSO Section will be applied to the parent's debt.
4. SRS may negotiate a Payment Agreement in lieu of or in addition to the SDSO process.
5. Parents with overdue balances not brought current by SDSO are to be mailed a Collection Letter stating the amount due and the need for them to contact DBHS within 10 days to set up a Payment Agreement that will pay the debt in a reasonable amount of time, usually within 12 - 24 months, depending on the size of the debt.
6. If the parent contacts DBHS within the 10 days, DBHS will make every reasonable effort to negotiate a mutually agreeable method for the debt to be paid.
  - a. DBHS will send the parent a written Payment Agreement to sign and return. The case will be monitored until the debt is paid in full.
  - b. DBHS will refer the matter to SRS Legal Section (see #7) if the payment agreement is not followed.
7. If the parent does not contact DBHS within 10 days, then the matter will be referred to the SRS Legal Section for additional action, which may include Judgment, Wage Garnishment, and Notification to Credit Bureaus. The SRS Legal Section will notify the parent of the referral, as appropriate, during the legal process. DBHS may be the

contact if the parent wants to discuss payments prior to the SRS Legal Section obtaining Judgment. DBHS will monitor all cases involved in the above Collection Process until the balance is paid and the matter is resolved to the satisfaction of SRS.

**Proviso to Establish a Parent Fee  
June 12, 2002**

Language of the Legislative Proviso\*\*

In addition to the other purposes for which expenditures may be made by the department of social and rehabilitation services from moneys appropriated from the state general fund or any special revenue fund for fiscal year 2003 for the department of social and rehabilitation services as authorized by this or other appropriation act of the 2002 regular session of the legislature, expenditures shall be made by the secretary of social and rehabilitation services for fiscal year 2003 to fix, charge and collect fees from parents for services provided to their children by an institution or program of the department of social and rehabilitation services:

Provided, That, in accordance with the provisions of federal law, the secretary of social and rehabilitation services shall not deny services to children under the home and community based services programs or the family preservation program based on the failure of any parent to pay such fees:

Provided further, That such fees shall be fixed by adoption of a sliding fee scale established by the secretary of social and rehabilitation services based on recommendations made by a working group including employees of the department, representatives of stakeholder organizations and family members and such fees shall recover all or part of the expenses incurred in providing such services:

And provided further, That such fees shall be waived in cases of demonstrable hardship and for families at or below 200% of the federal poverty level who are receiving home and community based services or family preservation services:

And provided further, That the secretary of social and rehabilitation services shall prepare and deliver a letter to the parents of every child who is receiving such services to express the need for payment of such fees to be made to the extent of their financial ability to do so:

And provided further, That all moneys received by the department of social and rehabilitation services for such fees shall be deposited in the state treasury to the credit of the social welfare fund:

And provided further, That at the beginning of the 2003 regular session of the legislature, the secretary of social and rehabilitation services shall submit a report to the committee on appropriations of the house of representatives, the committee on ways and means of the senate and to other appropriate standing and joint committees of the legislature on the status and the results of the fees collection program.

\*\* Underlines added

# REQUEST FOR A FEE VARIANCE

## Parent Fee Program

<b>Please Mail To:</b>	SRS/DBHS - Parent Fee Program 915 SW Harrison, DSOB 9th Floor West Topeka, KS 66612-1570	<b>Contact for Questions</b> <b>Phone:</b> (785) 296-3536 <b>E-Mail:</b> ParentFee@srs.ks.gov
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**(Print in Black or Blue Ink)**

Name of Parent/Guardian:	Date:
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Address:	City, State, ZIP:
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Daytime Phone Number: (     )	E-Mail:
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Name of Child:	Family ID # (as appears on bill):
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**Entire Fee Waiver Request (hardship)**  
*Examples of hardships include: Homelessness; loss of income that drops the family income to less than 200% of the FPL; high health care costs not covered by insurance; or costly damage to home or property not covered by insurance.*

**Fee Reduction Request (significant change)**  
*Examples of significant changes include: an increase in family size due to the birth of a child; loss of a job; or an income drop of 20% or more.*

**If any question does not apply to your situation write "Does Not Apply"**

**1) What is the significant change in circumstances, or hardship?** *(see example above)*

**2) What are the consequences and impact of the resulting financial burden?**

3) Is there a significant burden being placed on the family of a non-financial nature?

Yes  No

How:

4) Is the family's response to the deprivation or burden a result of events beyond the family's control, or rather the result of its own choosing? Explain:

5) What are the unusual, average monthly costs that are above and beyond the typical costs faced by families with a child with a disability as a result for the burden or hardship? Itemize, and then describe need.

<b>Average Monthly Cost for Product or Service</b>				
<b>Itemize the Product or Service</b>				

6) Is the family experiencing deprivation of essential needs like food, clothing, or shelter?

Yes  No

7) Estimate how long the deprivation or burden is likely to continue?

3-6 Months  6-12 Months  1 Year or More  Specific Date \_\_\_\_/\_\_\_\_/\_\_\_\_

8) Per Tax Return Adjusted Gross Income \$\_\_\_\_\_ Tax Year \_\_\_\_\_

Estimate Current Year's AGI (include any severance packages) \$ \_\_\_\_\_

**Provide a brief explanation for the variation:**

**Additional information you may want considered that is not included, please provide on additional sheet**  
*Examples of items you may want to include that support your request: Divorce Decree, child custody arrangement, unemployment determination, updated tax information, current pay check stubs, etc.*

**SRS may request additional information to consider Fee Variance Request**

***The information I've provided above is true and correct to the best of my knowledge.***

**Print Name:**

**Date:**

**Signature:**

**Date:**

**INFORMATION DISCLOSURE FORM***(Print in Black or Blue Ink)***Please Mail To:**SRS/DBHS - Parent Fee Program  
915 SW Harrison, 9th Floor West  
Topeka, KS 66612-1570**Contact for Questions**  
**Phone:** (785) 296-3536  
**E-Mail:** ParentFee@srs.ks.gov**Participant Information**

Name(s) of All Children Receiving Waiver Services			Age	Date of Birth	Medicaid ID #	SSN #	HCBS Wavier (See Key Below)	Relationship (See Key Below)
First	MI	Last						
Jed	E.	Doe	13	7/5/1996	000000000000	123-45-6789	DD	AC

*List Additional Participants On Separate Page***HCBS Waiver Program Key**

<b>AUT</b> - Autism	<b>SED</b> - Serious Emotional Disturbance
<b>DEV</b> - Developmental Disability/Mental Retardation	<b>TA</b> - Technology Assistance
<b>PHY</b> - Physical Disability	<b>TBI</b> - Traumatic Brain Injury

**Relationship Key**

<b>D</b> - Daughter/Step-Daughter	<b>S</b> - Son/Step-Son
<b>AC</b> - Adopted Child	<b>FOS</b> - Foster Child
<b>O</b> - Other (Specify):	

**Information of Individual Responsible for Fee Payment**

Parent/Guardian Name:	Social Security Number:
Address:	City, State, ZIP:
Daytime Phone Number: (     )	E-Mail:

**Did You File Income Tax Last Year****(Attach a copy of the first page of your Federal Income Tax Return)**

<input type="checkbox"/> <b>Yes</b>	Per Tax Return Adjusted Gross Income \$ _____	# of Exemptions (family size) ____
<input type="checkbox"/> <b>No</b>	Estimate Adjusted Gross Income \$ _____	# of Exemptions (family size) ____

**I do not believe a Parent Fee should be charged for the following reason(s). Check all that apply**

<input type="checkbox"/> Child is in foster care	<input type="checkbox"/> Relative other than a parent or step-parent	<input type="checkbox"/> Child is adopted <i>(provide copy of Adoption Decree)</i>
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**The information I have given is true and correct to the best of my knowledge**

Print Name:	Signature/ Certification:	Date:
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