|  |  |  |
| --- | --- | --- |
| ,- | 1. | **ATTACHMENTS TO THE MARCH 4, 2015 WORK PLAN**  *Choosing Which Service Method is Best tor Me* Brochure- 1.(b) |
|  | 2. | Self Determination Advisory Board Appointed Members and Designation List- 1. (c) |
|  | 3. | DDS ISP Forms and End Notes- 1.(e}(1) |
|  | 4. | DDS Waiver Services Definitions- 1.(e}(2} |
|  | 5. | MA Participant Directed Program Required Packets Forms Per Service- 1.(e)(4} |
|  | 6. | MA Participant Directed Program New Provider Paperwork Matrix- 1.(e)(4) |
|  | 7. | Sample PPL On Line Budget as Seen Through the Portal- 1.(e)(5} |
| ,-  '- - | 8.  9. | DDS ISP Appeal Documents- 1.(e}(6)  PPL Timesheetllnvoice- 1.(e)(7} |

10. PPL Monthly Budget Expenditure Report- 1.(e}(8)

11. Agency With Choice Qualified Providers -1.(e)(9)

12. CORI Form - 1.(1)

*(*

'

*r;====i* !=======-..

*(--,,*

**Whatisa.**

:=:::=.:::::\ 0

*()*

Choosing Which

**FISCALINTE DIARY?**

**(cont'd) .** .

. ·.

An FI does not make decisions about the amount or type of services you receive. The FI helps you to manage the supports that have already been identified in your ISP.

The FI works with the service providers you choose. If you choose to hire your own support workers, the **FI** will manage the paperwork and the responsibilities that come with being an employer. The FI will pay other vendors for special services and goods you have in your budget. The FI will

give you a monthly financial report to

let you know if you are spending what

you have budgeted on the items you

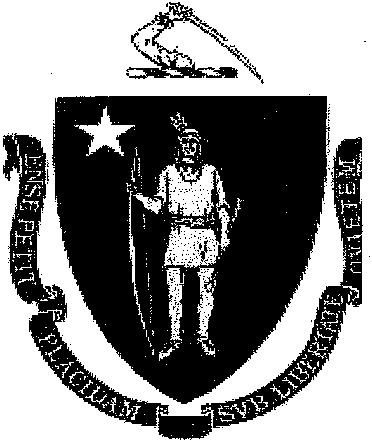
plarmed and if you are spending to much and need to make adjustments to stay within your budget. There is one FI in Massachusetts called Public Partnerships Limited, PPL, which is available statewide.

Your Area Office can provide you with additional information about services offered. Also, see the DDS website at: [www.mass.gov/dds.](http://www.mass.gov/dds)

Rev. 10/13

Service

l\t1ethod is Best for l\1e



Commonwealth of Massachusetts

Executive Office of Health and Human Services Marylou Sudders, Secretary

Department of

Developmental Services

Elin M. Howe, Commissioner

Self-Determination Advisory Board

NAME DESIGNATION

DDS Employee with knowledge/understanding

Mandy Chalmers/Gail Gillespie alternate of self-determination

Margaret Abrams Family member of individual self-directing Andrea Lunden Family member of individual self-directing Robin Foley Family member of individual self-directing

Lindsay Foley Individual who is self-directing

.

Sue Adams Family member of individual self-directing

Molly Adams Individual who is self-directing John Anton Individual who is self-directing Anne Fracht Individual who is self-directing

Joseph Wood Family member of individual self-directing

*(*

'--

Sam Wood Individual who is self-directing

Person with experience with self- Jeff Keilson determination models

John Nadworny Person with financial management services Leslie Kinney Provider of direct services, supports or goods Leo Sarkissian Member of an advocacy organization

Buddy Bostick An independent facilitator

Jim Brett Represent taxpayers

Experience with nonprofit and for-profit

Val Bradley services markets and competition and services for persons with disabilities Appointed by Disabled Persons Protection

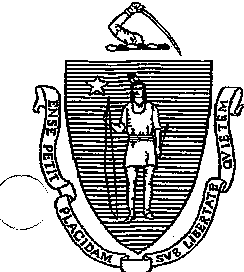
Julie Howley Westwater Commission

Jason Cofield Appointed by Office of the Inspector General

Marissa Szabo Appointed by the State Auditor

Shannon Choy-Seymour Experience with consumer protection (AGO)

7ie *e-IIUIII«<ea{d, tJ/.*



Executive Office of Health & Human Services

Department of Developmental Services

Individual Support Plan

NAME:

DATE OF MEETING:

DATE OF NEXT ANNUAL REVIEW:

DATE RANGE

SEMI ANNUAL REPORT

to

I INDIVIDUAL VISION FOR

1. What does (s)he identify as important activities and relationships to continue to be involved in? What other things would (s)he like to explore?

2. What does (s)he think someone needs to know in order to provide effective supports?

3. What does {s)he think are his/her strengths and abilities?

4. What would (s)he like to see happen in his/her life over the next two years?

II. CURRENT SUPPORTS (Services, Settings, and People): Home/Communitv:

Employment/Day: Health and Dental:

Adaptive Equipment/ Assistive Techno!oav:

Clinical:

Ill. SAFETY AND RISK

*(*

"

Revised 2/23/11- Pilot Version

IV. LEGAUFINANCIALIBENEFIT STATUS

LEGAL D Competent D Referred for Clinical

Team Review

'

"'"---

0 Guardian(s)

Name(s):

0 Conservator Name:

0 Rogers' Monitor(s) Name(s):

0 Health Care Agent Name:

0 Alt. Health Care Agent Name:

BENEFITS

0SSI 0 Mass Health 0 Other

OSSA 0 Medicare

0SSDI 0 VA

0 Representative Payee Name:

0 Power of Attorney Name:

FINANCIAL

0 Trust Fund 0 Burial Plan 0 Other

COMMENT

.

V. SUCCESSES, CHALLENGES, AND EMERGING ISSUES

Positive Events: Challenging Issues: Emerging Issues:

VI. GOALS

VI. OBJECTIVES

i

'--

Revised 6/15/2011 2

Individual Support Plan

UPDATE YEAR

NAME:

DATE OF UPDATE MEETING:

I. Individual Vision Update II. Current Support Update Ill. Health Update

IV. Safety *I* Risk Update

V. Legal/Financial/ Benefit Status Update

VI. Successes/ Challenges/ Emerging Issues

VII. Objectives Status

*(* .

''---

Revised 6/15/2011 3

**ENDNOTES**

,

i **INDIVIDUAL VISION-** The Individual's Vision Statement is an exploration of what is important to the person in his/her life. It should describe individual's preferences on how (s)he wishes to live, work and spend his/her leisure time as well as interests, relationships, and activities (s)he would like to continue and/or explore. If the individual is not able to fully express him/herself, please note the people and

sources of information that contributed to the answers to the 5 Vision questions. This statement should be

inserted before the first question so that readers understand how theVision Statement was developed.

**"VISION QUESTION 1** -These activities and relationships can be a springboard that will support the individual and his/her team, to create and pursue goals in the areas of employment, community connections, learning new skills, and building relationships, in support of his/her vision.

iii **VISION QUESTION** 2- Describe the infonmation the individual believes people need to know to support him/her to achieve what is important to him/her and to stay safe and healthy. Include how the person communicates and if there is any need for assistive technologies.

iv **VISION QUESTION** 3- Include positive traits, characteristics, ways of interacting, accomplishments and strengths.

v The **CURRENT SUPPORTS (SERVICES, SETTINGS AND PEOPLE)** section of the ISP should briefly but thoroughly describe the assessed needs of the individuals and the supports/services the individual receives to address those needs. Supports include those services that are arranged or provided by DDS, generic services, Mass Health services as well as natural supports.

vi **HOME-** Describe where and with whom the person lives. List what services are in place (natural, generic, DDS funded, or Mass Health services), the setting and service model (i.e. 24 hour residential

with or without PSS supports, Placement Services, Individual Home Support, Adult Foster Care, PCAs, or independent living). For individuals who receive limited supports, include the frequency and intensity of support that DDS has contracted for with the provider. Describe the assessed needs of the individual and the support the individual needs to assure health and safety and to promote independence (i.e. support with ADLs, money management, housekeeping, meal planning and preppration, access and involvement with the person's community and relationships, etc.). In addition, note the areas the individual/guardian has selected to develop additional skills through measurable goals and objectives.

vii **EMPLOYMENT/ DAY--** Describe what the person does during the day. List what services are in place and how the support is provided (natural, generic, DDS funded or Mass Health services). Describe the setting(s) (competitive employment, supported employment, group supported employment, center based work, center based day, day habilitation, adult day health, etc.) and the way transportation is managed to promote success in this area. List the number of hours the individual works. In addition, list the areas the individual/guardian has selected to develop additional skills through measurable goals and objectives. For individuals enrolled in Day Habilitation services, note "refer to Day Habilitation Plan" and attach it to the ISP. For individuals who receive supplements to their Day Habilitation service note: "Supplemental services are provided in addition to the Day Habilitation services to assure individual health and safety".

viii **HEALTH AND DENTAL** --Briefly summarize the individual's health and dental support needs. List any health care protocols, dietary needs, and whether or not the individual is capable of self-medicating. For individuals who have a current Health Care Record note "Refer to Health Care Record" and attach it to the ISP. A list of health care providers and medications and the dates of the dates of the annual physical and dental examinations is included in the HCR and need not be replicated here.

For individuals without a Health Care Record note the individual's health and dental care needs, the names of health care providers and the list of medications and their purpose, to the degree that this

*-* information is provided by the individual/guardian. If known, list the dates of annual physical and dental examinations and anyspecialists the individual sees (i.e. Neurologist, orthopedist, etc.).

Revised 6115/2011 4

If the individual has significant health risks (PICA, obesity, etc.) please list the risk(s) and the supports provided to address and minimize these risk(s) to the greatest degree possible. Please note that HIV status is not included in either record.

ix ADAPTIVE EQUIPMENT/ ASSISTIVE TECHNOLOGY- List the types of adaptive equipment and/or assistive technology the person needs at work or home, including health related protective devices. Adaptive equipment and assistive technology includes mobility devices (wheel chairs, walkers, braces, etc.), ADL aides, bed shakers, strobe lights, adaptive telephones, jigs, mealtime devices (mats, adaptive cutlery), etc.

x CLINICAL - List the clinical supports the individual receives including physical therapy, occupational therapy, speech and language, psychotherapy, and/or psychiatric care. Note if the individual has or needs a psychotropic medication treatment plans. For individuals taking anti-psychotic medication that is overseen by a Rogers Monitor, note, "refer to Rogers Order for details". For individuals with behavior plans, note the behaviors being addressed and the level of the plan.

The reason for and effectiveness of the clinical supports provided over the past year should be included in the assessments developed by service providers and reviewed at the ISP meeting.

xi SAFETY - Briefly describe the person's safety skills and abilities at home and in the community, his/her supervision needs, and under what circumstances, if any, (s)he can be alone including if transportation providers can leave people unattended. For individuals in 24 hour residential programs, indicate his/her ability to evacuate in case of emergency within 2.5 minutes. If a wavier related to evacuation has been authorized, please note it here.

RISK -- Briefly describe the circumstances, if any, where the individual poses a significant risk to him/herself and/or the community. Describe supports provided to minimize risks to the individual and others, including specific supervision needs related to the identified risks. Also indicate specific staffing requirements in each program setting required to mitigate risk to the individual and or community (i.e. line of sight, 1:1, and arm's length).

xH GUARDIAN - For extent of guardianship authority refer to guardianship decree

'""HEALTH CARE AGENT- The individual must have the capacity to understand and select a Health Care Agent. People under guardianship cannot execute a HCP; however, previously executed HCPs remain valid even if a Guardianis subsequently appointed.

xiv COMMENT -- note if there are any financial issues that put the individual's Mass Health in jeopardy. "" POSITIVE EVENTS -List the successes the individual has had over the past year at hom '!, at work,

and other areas important to the person.

xvi CHALLENGING ISSUES -Indicate issues that are continuing to be difficult for the individual and any obstacles that interfere with his/her ability to engage in activities.

,;E; MERGING ISSUES --Briefly note newly identified changes in the individual's abilities or life circumstances that require specific attention, including requests for a change in services.

xvin GOALS -- List the goals the ISP team has agreed to address over the next 2 years that relate to the

Individual Vision.

xD< OBJECTIVES -- List the objectives the ISP team has agreed to address over the next 2 years that relate to the Individual Vision and Goals.

I

"--

Revised 6/15/2011 *5*

**DDS Waiver Service Definitions** -

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Waiver* | *Service* | *Service Name* | *Agency* | *Individual* | ***Agell(V*** | *Relative'* | *Service Definition* | *Service Limit5* | *Rates* |
|  | *Code* |  | *with* | *Provider* | *Provider* | *Able to* |  |  |  |
|  |  |  | *Choice* |  |  | *Provide* |  |  |  |
|  |  |  |  |  |  | *Service?* |  |  |  |
| Adult | 5703 | Individualized | Yes | Yes | Yes | Yes | Individualized Home Supports consists of services and | This service is 23 hours or | Maximum |
| Supports, Community Living & Intensive Supports | 6703 | Home  Supports |  |  |  |  | supports in a variety of activities that may be provided regularly but that are less than 24 hours per day that are  determined necessary to prevent institutionalization. This service provides the support and supervision necessary for the participant to establish, live in and maintain on an on-going basis a household of their choosing, in a personal home or the family home to meet their habilitative needs. These services assist and support the waiver participant and may include teaching and  fostering the acquisition, retention or improvement of  skills related to personal finance, health, shopping, use of community resources, community safety, and other  social and adaptive skills to live in the community as specified in the Plan of Care. It may include training and education in self-determination, self advocacy to enable the participant to acquire skills to exercise control and responsibility over the services and supports they receive to become more independent, integrated and productive in their communities. The service includes elements of community habilitation and personal assistance. This | less per day. This service is  not available to participants who receive residential habilitation or receive 24 hour self-directed home sharing supports. This service may  not be provided at the same time as Respite, Group or Individual Supported Employment, Center-Based Work Supports, Community Based Day Supports, Individualized Day Supports, Individualized Goods and Services, or Adult Companion or when other services that include care and supervision are provided. The locating of appropriate housing is not covered as part of this service. | rate of  $30.04/hour |
|  | | | | | | | service excludes room and board, or the cost of facility |  |  |
| upkeep, and maintenance. An assessment is conducted |  |  |
| and a Plan of Care is developed based on that |  |  |
| assessment. The service is limited to the amount |  |  |
| specified in the waiver participant's Plan of Care. This |  |  |
| service may be delivered in a one's own home, or a |  |  |
| family home, or in the community. No individual |  |  |

Rev9/29/2014 Page 1

*()*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Waiver* | *Service* | *Service Name* | ***AgeiUJ'*** | *Individual* | *Agency* | *Relative'* | *Service Definition* | *Service Limits* | *Rates* |
|  | *Code* |  | *with* | *Provider* | *Provider* | *Able to* |  |  |  |
|  |  |  | *Clwice* |  |  | *Provide* |  |  |  |
|  |  |  |  |  |  | *Service?* |  |  |  |
|  |  |  |  |  |  |  | provision duplicates services provided under Targeted |  |  |
|  |  |  |  |  |  |  | Case Management. This service may be self-directed |  |  |
|  |  |  |  |  |  |  | through either the Fiscal Intermediary or Agency with |  |  |
|  |  |  |  |  |  |  | Choice. |  |  |
| Adult | 5707 | Adult | Yes | Yes | Yes | Yes | Non-medical care, supervision and socialization provided | This service is 23 hours or | Maximum |
| Supports, | 6707 | Companion |  |  |  |  | to an adult. Services may include assistance with meals | less per day. It is available to | rate of |
| Community |  |  |  |  |  |  | and basic activities of daily living such as shopping, | individuals who live in their | $20.28/hour |
| Living & |  |  |  |  |  |  | laundry, meal preparation, routine household care | family home or in a home of |  |
| Intensive |  |  |  |  |  |  | incidental to the support and supervision of the | their own. This service may |  |
| Supports |  |  |  |  |  |  | individual. The service is provided to carry out personal | not be provided at the same |  |
|  |  |  |  |  |  |  | outcomes identified in the individual plan that support | time as Chore, Individualized |  |
|  |  |  |  |  |  |  | the individual to successfully reside in his/her home or in the family home. Adult companion may *also* be provided | Home Support, Respite,  Group or Individual |  |
|  |  |  |  |  |  |  | when the caregiver regularly responsible for these | Supported Employment, |  |
|  |  |  |  |  |  |  | activities is temporarily absent or unable to manage the | Individualized Day Supports, |  |
|  |  |  |  |  |  |  | home and care. Adult companion services are also | Center Based Day Supports, |  |
|  |  |  |  |  |  |  | available for an individual in his/her own residence who | Community Based Day or |  |
|  |  |  |  |  |  |  | requires assistance with general household tasks. This | when other services that |  |
|  |  |  |  |  |  |  | service does not entail hands on nursing care. Provision | include care and supervision |  |
|  |  |  |  |  |  |  | of services is limited to the person's own home, family | are provided. |  |
|  |  |  |  |  |  |  | home, or in the community. This service may be self- |  |  |
|  |  |  |  |  |  |  | directed through either the Fiscal Intermediary or through |  |  |
|  |  |  |  |  |  |  | Agency with Choice. |  |  |
| Adult | 5710 | Behavioral | No | Yes | Yes | No | Behavioral supports and consultative services are clinical | Access to this service is only | Maximum |
| Supports, |  | Supports and |  |  |  |  | and therapeutic services and that are necessary to | permissible by prior | rate of |
| Community |  | Consultation |  |  |  |  | improve the individual's independence and integration in | authorization through the | $122.27/hour |
| Living & |  |  |  |  |  |  | their home or in their community. This service is | Area Office Psychologist or |  |
| Intensive |  |  |  |  |  |  | available to waiver participants and is designed to | the Area Director. If the |  |
| Supports |  |  |  |  |  |  | remediate identified challenging behaviors or to acquire | waiver participant has a co- |  |
|  |  |  |  |  |  |  | socially appropriate behaviors. Behavioral supports and | occurring mental health |  |
|  |  |  |  |  |  |  | consultation are provided by professionals in the fields of | djagnosis those services must |  |

Rev9/29/2014 Page 2

*(* \ *I*

\ I \\_/

*Waiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limits Rates*

*Code with Provider Provider Able to*

*Clwice Provide*

*Service?*

psychology, mental health, or special education. The be accessed through the

. service may include a a) functional assessment by a Medicaid State Plan. trained clinician, b) the development of a positive

behavior support plan which includes the teaching of

new skills for increasing new adaptive replacement behaviors, decreasing challenging behavior(s) in the individual's natural environments, c) intervention strategies, d) implementation of the positive behavior support plan and associated documentation and data analysis, and e) monitoring of the effectiveness of the plan. Monitoring of the plan will occur at least monthly or more frequently as needed. The service will include any change to the positive behavior support plan when necessary and the professional(s) shall be available to provide recommendations to the ISP team and the Targeted Case Manager including making referral recommendations to community physicians and other clinical professionals that support the assessment findings. In order to carry out supports to Waiver Participants, training, consultation and technical

assistance to paid and unpaid caregivers may be provided to enable them to understand and implement the positive behavioral plan at home. This service does not provide direct services to either paid or unpaid caregivers. The behavioral supports and consultation must be consistent with the DDS regulations. This service is available in the waiver participant's home or in the community. Behavioral Supports and Consultation does not include any service covered by the Medicaid State Plan including individual, group, or family counseling or under private insurance including benefits under ARICA. Providers must first access behavioral supports and consultation

Rev9/29/2014 Page 3

(

*Waiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limits Rates*

*Code witlt Provider Provider Able to*

*Choice Provide*

*Service?*

through their own agency. This service may be self- directed through the Fiscal Intermediary.

Adult 5731 Home No Yes Yes Yes Those physical adaptations to the private residence of the Not to exceed $15,000 in a Supports, Modifications participant, required by the participant's serviCe plan, five-year period. Only Community and that are necessary to ensure the health, welfare, and available to individuals who Living & Adaptations safety of the individual, or that enable the individual to live in the family home or in a Intensive function with greater independence in the home. Service home of their own. Not Supports includes the assessment and evaluation of home safety available to providers of

modifications. This service can only be provided in the residential supports or 24 hour individual's primary residence. Such adaptations include self-directed home sharing in

but are not limited to: the care provider's home.

• Installation of ramps and grab-bars Excluded are those

• Widening of doorways/hallways

adaptations or improvements

to the home that are of general

---

L\_

• Modifications of bathroom facilities utility, and which are not of

• Lifts: porch or stair lifts direct medical or remedial

• Installation of specialized electric and plumbing benefit to the individual, such

systems which are necessary to accommodate the *as* carpeting, roof repair,

medical equipment and supplies, and which are central air conditioning.

necessary for the welfare of the individual Adaptations that add to the

• Installation of specialized flooring to improve total square footage of the

mobility and sanitation home are excluded from this

• Specialized accessibility/safety adaptations/additions benefit except when necessary

• Automatic door openers/door bells to compJete an adaptation.

• Voice activated, light activated, motion activated and General household repairs are

electronic devices not included in this service.

• Door and window alarm and lock systems No permanent adaptations to

• Air filtering devices and cooling adaptations and the structure will be made to

devices property rented or leased by

• Specialized non-breakable windows the participant, guardian or

All services shall be provided in accordance with State or legal representative.

-

Rev 9/29/2014 Page4

I

\ *\ )*

*T¥aiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limits Rates*

*Code wit/1 Provider Provider Able to*

*Clwice Pro11ide*

***Service?***

Local Building codes.

Any use of Waiver funds for home adaptation requests must be submitted and approved in advance following

the process outlined below. The Service Coordinator will explore with the individual and family when relevant, utilization of appropriate modifications that are portable to accommodate changes in residence, size of the individual, and changes in equipment and needs. In

addition, all proposals for home adaptations shall plan for the reuse of portable accommodations.

a) Waiver funding shall only be used for renovations that will allow the individual to remain in his/her home (primary residence), and must specifically relate to the functionallimitation(s) caused by the individual's disability. It is not available to individuals who visit home periodically but who otherwise reside elsewhere.

b) The following steps to request approval for funding must be followed.

• The Service Coordinator must receive for his/her review and recommendation the following

information: a proposal detailing the request for funding, and the completed Vehicle/Home Adaptations Funding Request Form. The participant's Individual Support Plan that clearly defines and explains the need for a home adaptation must be attached to this information.

• If the DDS Service Coordinator recommends the proposal for funding, the request is then forwarded to

the Area and then the Regional Director for review and recommendation of funding.

Rev 9/29/2014 Page 5

/ *i*

(

*\_/*

*Rates*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Waiver* | *Service* | *Service Name* | *Agency* | *Individual* |  | *Agency* |  | *Relative'* | *Service Definition* | *Service Limits* |
|  | *Code* |  | *\Vit/1* | *Provider* |  | *Provider* |  | *Able to* |  |  |
|  |  |  | *Choice* |  |  |  |  | *Provide* |  |  |
|  |  |  |  |  |  |  |  | *Service?* |  |  |

• If a home adaptation request is approved, the individual/family must submit, at a minimum, 3 bids

that contain costs and a work agreement, to the

Department.

c) All payments for Home Adaptations must be made through the Fiscal Management Service and purchased through a self directed budget. This service must be an identified need and documented in the service plan. The Home Adaptations must be purchased through a self- directed budget through the Fiscal Intermediary. Funding for Home Adaptations is not available for use in any state operated or provider residence, or in the home of a home sharing care provider.

Adult 5168 Individualized No Yes Yes Yes Individual supported employment services consist of Up to 184 hours in Supports, 5180 Supported ongoing supports that enable a participant, for whom combination with other day Community Employment competitive employment at or above the minimum wage services. Maximum number Living& is unlikely absent the provision of supports, and who, of hours varies per month but Intensive because of his/her disabilities, need support to perform in total carmot exceed 184 hours Supports a regular work setting. Individual supported employment of combined day services as

may include assisting the participants to locate a job or expressed in 8 hours per day.

develop a job on behalf of the participant. Individual supported employment is conducted in a variety of settings, particularly typical work sites where persons without disabilities are employed. Emphasis is on work in an integrated environment with the opportunity for individuals to have contact with co-workers, customers, supervisors and others without disabilities. In individual supported employment the individual has a job based on his/her identified needs and interests, located in a community business. It may also include self- employment or a small business, or a home-based self- employment, or temporary services which may assist an

Rev 9/29/2014 Page 6

*)* c \

*j*

*Waiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limits Rates*

*Code with Provider Provider Able to*

*Choice Provide*

*Service?*

individual in securing an individual position within a business Individual supported employment may include job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching in the form or regular or periodic assistance; training and support are provided for the purpose of developing, maintaining and/or improving job skills and fostering career advancement opportunities. Job coaching at the job site is not designed to provide continuous on-going support; it is expected that as the individual develops more skill and independence the level of support will

decrease and fade over time as the natural supports in the

work place are established. Some ongoing intermittent job related support may be provided to assist the waiver participant to successfully maintain his/her employment situation. Natural supports are developed by the provider to help increase inclusion and independence of the individual within the community setting. Individuals are paid by the employer. It may include transportation if not available through another source. Transportation assistance between the participants' place of residence

and the employment site is included in the rate paid to providers of individual supported employment services. Ongoing transportation for an individual participant is excluded from the rate. Time-limited transportation for components of discovery, career exploration, job development is provided. Once the individual is hired, transportation ceases. Individual supported employment may be self-directed and paid through the Fiscal Intermediary.

Rev 9/29/2014 Page 7

( \. '

'

*Waiver Service Service Name Agency Individual Agency Relative Service Definition Service Limits Rates*

*Code with Provider Provider Able to*

*Choice Provide*

***Service?***

Federal fmancial participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for training that is not directly related to a participant's supported employment program.

When supported employment services are provided at work sites where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required for participants receiving the waiver service as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) Individual supported employment excludes individuals working in mobile crews or in small groups. It excludes volunteer work.

Adult 5243 Occupational No Yes Yes No Occupational Therapy Services, including the No more than one individual Maximum Supports, Therapy performance of a habilitative or maintenance program treatment and one group rate of Community provided by a licensed Occupational Therapist. therapy session per day may $71.20/visit Living & Occupational therapy programs are designed to improve be authorized.

Intensive the quality of life by recovering competence, preventing

Rev 9/29/2014 PageS

*(* (

*Waiver Service Service Name* ***AgellLJ'*** *Individual Agency Relative' Service Definition Service Limits Rates*

*Code with ProJJider ProJJider Able to*

*Choice Provide*

*Service?*

Supports further disability or injury and/or to improve the individual's ability to perform tasks of daily living required for independent functioning and to ameliorate sensory issues.. The practice of Occupational Therapy encompasses evaluation, treatment, and consultation. Occupational Therapy services promote/maintain fine motor skills and coordination. Services are habiltiative and are designed to maintain or prevent the worsening of functioning. Occupational therapy services include but are not limited to specifically designed activities and exercises to teach daily living skills and to develop independent skills to enhance the areas of neurodevelopment, cognition, perceptual motor, sensory integrative and psychomotor functioning. OT may also design or apply selective orthotic or prosthetic devices or selected adaptive equipment and assist in the design of adapting environments. Services may also include the training and oversight necessary for the participant, family member or another person to carry out the

maintenance program. Occupational Therapy under the

waiver is different from State plan services in nature and scope in that they allow for maintenance therapy not otherwise covered under the State plan. Services are delivered in both offices and in the natural environments of the participant. The service may be provided individually and in small groups, in the natural milieu of the individual or in the community. The provider qualifications specified in the State Plan apply. Occupational Therapy services must be authorized by the Service Coordinator as part of the ISP Team process.

This service is not subject to the Medical Referral

Requirements found at 130 CMR 432.414 or the

Rev 9/29/2014 Page 9

L,

*Waiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limit.\ Rates*

*Code witII Provider Provider Able to*

*Choice Provide*

***Service?***

requirements for Prior Authorization found at 130 CMR

432.417. The Occupational Therapy must be evidence- based and conform with acceptable medical practice; no experimental or alternative treatments are permitted. Any devices used in the provision of the service must be FDA approved. This service will not duplicate any services available through the Medicaid State Plan or private health insurance. This service cannot occur in Day Habilitation or in other sites where therapy is being provided. Payment will not be made for a treatment for the same date of service as a comprehensive evaluation. Occupational therapy must be purchased through a self- directed budget through the Fiscal Intermediary. This service is subject to the service limitations included in

130 CMR 432.414 (A) and (B). No more than one

individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of services as a

comprehensive evaluation.

.

Adult 5240 Physical No Yes Yes No Physical Therapy services, including the performance of No more than one individual Maximum Supports, Therapy a habilitative or maintenance program, provided by a treatment and one group rate of Community licensed Physical Therapist. Services must be considered therapy session per day may $68.30/visit Living & necessary by DDS for the participant to habilitate, be authorized.

i

Intensive maintain or prevent the worsening of functioning.

Supports Services are directed toward the management of movement dysfunction and/or the enhancement of

physical and functional abilities. Physical Therapy Services promote/maintain gross/fine motor skills and facilitate independent functioning. Services may also include the training and oversight necessary for the participant, family member or other person to carry out the maintenance program. Physical Therapy under the

Rev 9/29/2014 Page 10

*I*

I.

*Waiver Service Service Name Agency Individual Agency Relative' Service Definilion Service Limits Rates*

*Code with Provider Provider Able to*

*Clwice Provide*

*Service?*

waiver is different from State plan serVices in nature and scope in that they allow for maintenance therapy not otherwise covered under the State plan. The provider qualifications specified in the State Plan apply. Physical Therapy services must be authorized by the Service Coordinator as part of the Individual Service Plan. The Physical Therapy must be evidence-based and conform with acceptable medical practice; no experimental or alternative treatments are permitted. Any devices used in the provision of the service must be FDA approved. Services are delivered in both offices and in the natural environments of the participant. The service may be provided individually and in small groups. This service is not subject to the Medical Referral Requirement found at

130 CMR 432.415 or the requirements for Prior Authorization found at 130 CMR 432.417. This service will not duplicate any services available through the Medicaid State Plan or private health insurance. This service cannot occur in Day Habilitation or in other sites where the therapy is being provided. No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a therapy in which there is no DDS assessment or authorization. Payment will not be made for a treatment for the same date of service as a comprehensive

evaluation. Physical Therapy must be purchased through

!

a participant-directed budget through the Fiscal

Intermediary. This service is subject to the service limitations included in 130 CMR 432.414(A) and (B). Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.

Rev9f29/2014 Page 11

*I*

*)*

\

I

*l*

*J* /

*Waiver Service Service Name Agency Individual Agency Relative; Service Definition Service Limits Rates*

*Code wit!t Provider Provider Able to*

*Choice Provide*

***Service?***

Adult 5245 Speech No Yes Yes No Speech Therapy services, including the performance of a No more than one individual Maximum Supports, Therapy habilitative or maintenance program provided by a treatment and one group rate of Community licensed Speech Therapist. Services are habiltiative and therapy session per day may $72.88/visit Living & are designed to maintain or prevent the worsening of be authorized.

Intensive . functioning in the areas of communication and ability to

Supports eat, drink, swallow and manage aspiration risks. Speech- language pathology refers to the application of

principles, methods and procedures related to the development of disorders that impede oral, pharyngeal, or laryngeal competencies and the normal process of human communication including but not limited to disorders of speech, articulation, fluency, voice, and the application of augmentative communication treatments. Services may also address swallowing dysfunction. Services may also include the training and oversight necessary for the participant, family member or other person to carry out the maintenance program. Speech Therapy under the waiver is different from State plan services in natnre and scope in that they allow for maintenance therapy not otherwise covered under the State plan. Service may be delivered in both offices and in the natural environments of the participant. The service may be provided individually or in small groups. The provider qualifications in the State Plan apply. Speech Therapy services are authorized by the Service Coordinator as part of the ISP Team process.. The

Speech Therapy must be evidence-based and conform with acceptable mediciil practice; no experimental or alternative treatments are permitted. Any devic.es used in the provision of the service must be FDA approved. The service can only be provided by licensed personnel. This service is not subject to the Medical Referral

Rev 9/29/2014 Page 12

I

'

***Waiver*** *Service Service Name Agency Individual Agency Relative Service Definition Service Limits Rates*

*Code with Provider Provider Able to*

*Choice Provide*

*Service?*

Requirements found at 130 CMR 432.414 or the requirements for Prior Authorization found at 130 CMR

432.417. This service will not duplicate any services available through the Medicaid State Plan or private health insurance. This service can not occur in Day Habilitation or in other sites where therapy is being provided. No more than one individual treatment and one group therapy session per day may be authorized.. Payment will not be made for a treatment for the same date of service as a comprehensive evaluation. Speech Therapy must be purchased through a self directed

budget through the Fiscal Intermediary. This service is

subject to the service limitations included in 130 CMR

432.414 (A) and (B). Payment will not be made for a treatment claimed for the same date of services as a comprehensive evaluation.

Adult 5196 Transportation No Yes Yes Yes Service offered in order to enable waiver participants to Transportation that is part of a Supports, 5197 gain access to waiver and other community services, day or residential program or Community 5198 activities and resources, as specified by the service plan. a contracted transportation Living & Transportation services under the waiver are offered in provider cannot be self- Intensive accordance with the participant's service plan. Whenever directed.

Supports possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. This service includes travel to and from day programs and travel for accessing community activities and resources. Transportation may also include the purchase of transit and bus passes for public transportation systems and mileage reimbursement for qualified drivers. The provision of transportation is based on a service plan that meets the need in the most cost- effective manner. This service is offered in addition to medical transportation required under 42 CFR 431.53

Rev9/29/2014 Page 13

'.. /

I

( ' )

"'----"

*Waiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limits Rates*

*Code with Provider Provider Able to*

*Choice Provide*

*Service?*

and transportation services under the State Plan defined at 42 CFR 440.170 (a), and does not replace them.

Adult 5701 Respite Yes Yes Yes Yes Services are provided in either: a) licensed respite 30 days per year. Payment Maximum Supports, 6701 facility, b) in the home of the participant, c) in the family will not be made for respite at rate for Community 5702 home, or d) in the home of an individual family provider the same time when other 5701(in Living & to waiver participants who are unable to care for services that include care and recipient's Intensive themselves. Services are provided on a short-term supervision are provided. home) Supports overnight basis where there is an absence or need for Respite may not be provided $224.29/day

relief of those persons who normally provide care for the at the same time as 5702 (in participant or due to the needs of the waiver participant. Individualized Goods and caregiver's Respite care may be made available to participants who Services, when a service home) receive other services on the same day, such as Group or rather than a good is being $145.57/day Individual Supported Employment, Centered Based provided. Facility-based

Work Supports or adult day-care. Others forms of respite cannot be participant- respite may be self-directed. The choice of the type of directed.

respite is dependent on the waiver participant's living situation. Federal fmancial participation will only be claimed for the cost of room and board when provided as part of respite care furnished in a facility licensed by the state. Respite may be provided up to 30 days per year

and is reflected in the Individual Service Plan based on assessed need.

Adult 5283 Assistive No Yes Yes No Assistive technology is defined as an item, piece of Waiver funding shall only be Supports, Technology equipment, or product system, whether acquired used for assistive technology Community commercially, modified, or customized, including the that is specifically related to Living& design and fabrication that is used to develop, increase, the functionallimitation(s) Intensive maintain, or improve functional capabilities of caused by the individual's Supports participants. Assistive technology service means a disability. Any Assistive

serVice that directly assists a participant in the selection, Technology item that is

acquisition, rental, or customization or use of an assistive available through the State technology device. This service also covers maintenance, Plan must be purchased

Rev9/29/2014 Page 14

I'-, */'* '

*!*

',.

I \

*"--)*

*Waiver Service Service Name Agency Individual Agency Relative Service Definition Service Limits Rates*

*Code wit!t Provider Provider Able to*

*Cfloice Provide*

*Service?*

repairs of devices and rental of assistive technology through the State Plan; only during periods of repair. Assistive technology includes - items not covered by the State the evaluation of the assistive technology needs of the Plan may be purchased participant, including a functional evaluation of the through the Waiver.

impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for participants; services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan; training or techuical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and training or technical assistance for professionals or other individuals who provide services

to, employ, or are otherwise substantially involved in the

major life functions of participants. Assistive Technology must be authorized by the Service Coordinator as part of the Individual Service Plan. The Service Coordinator will explore with the individual/legal guardian the use of the Medicaid State Plan. Assistive technology must be purchased through a self-directed budget through the Fiscal Intermediary. Adaptive Aids must meet the Underwriter's Laboratory and/or Federal Communications Commission requirements where applicable for design, safety, and

Rev 9/29/2014 Page 15

*(* ( \

I\_ ' *J*

*Waiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limits Rates*

*Code witIt Provider Provider Able to*

*Choice Provide*

***Service?***

utility. There must be documentation that the item purchased is appropriate to the participant's needs.

Adult 5725 Chore No Yes Yes Yes Services needed to maintain the home in a clean, In the case of rental property, Maximum Supports, sanitary, and safe environment. This service includes the responsibility of the rate of Community minor home repairs, general housekeeping and heavy landlord, pursuant to the lease $28.16fhour Living& household chores such as washing floors, windows, and agreement, is examined prior

Intensive walls, tacking down loose rugs and tiles, moving heavy to any authorization of the

Supports furniture in order to provide safe egress and access. service. Service is not These services are only provided when neither the available in a provider participant nor anyone else in the household is capable of operated setting. performing or financially providing for them and where

no other relative, caregiver, landlord,

community/volunteer agency, or third party payer is responsible for their provision. Chore service must be paid through a self-directed budget through the Fiscal Intermediary.

Adult 5709 Family Yes Yes Yes No Family Training is designed to provide training and This service is not available to Supports, 6709 Training instruction about the treatment regimes, behavior plans, individuals who reside in a Community the use of specialized equipment that supports the residential setting who do not Living & individual waiver participant to participate in the have regular contact with Intensive community. Family Training may also include training in family. Family does not Supports family leadership, support of self-advocacy, and include individuals who are

independence for their family member. The service employed to care for the enhances the skill,of the family to assist the waiver individual.

participant to function in the community and at home. Documentation in the individual's record demonstrates the benefit to the individual. For the purposes of this service "family" is defmed as the persons who live with or provide care to a waiver participant and may include a parent or other relative. Family Training may be

provided in a small group format or the Family Trainer

Rev 9/29/2014 Page 16

I *j* '

*(*

I'- /'

*Waiver Service Service Name Agency Individual Agency Relativ/ Service Dejinilion Service Limits Rates*

*Code with Provider Provider Able to*

*Choice Provide*

*Service?*

may provide individual instruction to a specific family based on the needs of the family to understand the specialized needs of their family member. The one to one family training is instructional; it is not counseling. Service is available to those waiver participants who either live in the family home, receive less than 24 hours of support per day and for those individuals who

regularly visit their family home from a residential setting. This service may be self-directed.

Adult 5728 Individual No Yes Yes No Individual Goods and Services are services, equipment or This service is limited to Supports, Goods and supplies that will provide direct benefit and support $1,500 per waiver year. Community Services specific outcomes that are identified in the individual Experimental and prohibited Living & waiver participant's service plan. The Individual Goods treatments are excluded. The Intensive and Services are not provided through either other waiver Individual Goods and Supports services or the Medicaid State Plan. The Individual Services may not be provided

Goods and Services promote community integration, or at the same time as respite, or

provide resources to expand opportunities for self- any employment or day advocacy, or decrease the need for other Medicaid activity program. Individual services, or reduce the reliance on paid support, or are Goods and Services excludes directly related to the health and safety of the waiver all services and supplies participant in his/her home or community. Individual provided under specialized Goods and Services are used when the waiver participant medical equipment and

does not have the funds to purchase the item or service supplies or assistive from any other source. Examples of allowable Individual technology.

Goods and Services include: Enrollment fees, dues,

membership costs associated with the individual's participation in community habilitation, training, supplies, and materials that promote skill development and increased independence for the individual with a disability in accessing and using community resources. The Individual Goods and Services must be purchased through a self-directed budget. This service must be pre-

Rev 9/29/2014 Page 17

*(*

(

\

. ' *\_j*

/

*Waiver Service Service Name Agency Individual AJ.:ency Relative' Service Definition Service Limits Rates*

*Code JVitlt Provider Provider Able to*

*Choice Provide*

*Service?*

approved by the Team and subject to DDS rules and

. must be an identified need and documented in the service plan. This service must be self-directed paid through the Fiscal Intermediary.

Adult 5704 Individualized Yes Yes Yes Yes Services and supports provided to individuals tailored to Up to 184 hours in Supports, 6704 Day Supports their specific personal goals and outcomes related to the combination with other day Community acquisition, improvement, and/or retention of skills and services. Maximum number Living & abilities to prepare and support an individual for work of hours varies per month but Intensive and/or community participation and/or meaningful total carmot exceed 184 hours Supports retirement activities, and could not do so without this of combined day services as

direct support. This service can only be participant- expressed in 8 hours per day. directed. A qualified family member or relative, This service is not provided in independent contractor or service agency may provide or from a facility-based

services. This service originates from the home of the (center-based or community individual and is generally delivered in the community. based) day program. This

Examples service is not provided from a provider-operated or state-

• Develop and implement an individualized plan for operated group residence.

day services and supports; This service may not be

• Assist in developing and maintaining friendships of provided at the same time as

choice and skills to use in daily interactio s; Group or Individual

• Provide support to explore job interests or retirement Supported Employment, options; Center- based Work Supports,

• Provide opportunities to participate in community Community Based Day activities, including support to attend and participate Supports, Individualized

in post-secondary or adult education classes; Goods and Services Supports

• Provide support to complete work or business or when other services that activities including supports for individuals who own include care and supervision their own business; are provided.

• Training and support to increase or maintain self- help, socialization, and adaptive skills to participate

Rev 9/29/2014 Page 18

c

*Waiver Service Service Name Agency Individual* ***Agenc:,v*** *Relative' Service Definition Service Limits Rates*

*Code with Provider Provider Able to*

*Choice Provide*

*Service?*

in own community;

• Develop, maintain or enhance independent functioning skills in the areas of sensory-motor,

cognition, personal grooming,hygiene, toileting, etc. This service is only available to waiver participants who self-direct his/her own supports and must be pre- approved by the Team, subject to **DDS** rules stated

above, and must be an identified need and documented in the service plan. The Individualized Day Supports must

be purchased through a self-directed budget through

either the Fiscal Intermediary or the Agency with Choice.

Adult 5716 Peer Support Yes Yes Yes No Peer support is designed to provide training, instruction Supports, 6716 and mentoring to individuals about self-advocacy, Community participant direction, civic participation, leadership, Living & benefits, and participation in the community. Peer Intensive support is designed to promote and assist the waiver Supports participant's ability to participate in self-advocacy

through either a peer mentor or through an individual/agency peer support facilitator. Peer support may be provided in 1) small groups or 2) peer support may involve one individual who is either a peer or an individual peer support facilitator providing support to a waiver participant. The one to one peer support is instructional; it is not counseling. The service enhances the skills of the individual to function in the community and/or family home. Documentation in the individual's record demonstrates the benefit to the individual. This service may be provided in small groups or as a one-to- one support for the individual. Peer support is available to individuals who receive less than 24 hours of support

.. .

per day and those who reside in residential settings. This I

Rev9/29/2014 Page 19

(

*Waiver Service Service Name Agency Individual Agency Relativl Service Definition Service Limits Rates*

*Code witlz Provider Provider Able to*

*Choice Provide*

*Service?*

service may be self-directed.

Adult 5756 Specialized No No Yes Yes Specialized medical equipment and supplies include: (a) This service is limited to Supports, Medical devices, controls, or appliances, specified in the plan of $3,500 per waiver year. Community Equipment care, that enable participants to increase their ability to

Living & and Supplies perform activities of daily living; (b) devices, controls, or Intensive appliances that enable the participant to perceive, control, Supports or communicate with the environment in which they live; (c) items necessary for life support or to address physical

conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to

address participant functional limitations; and, (e) i

necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. Accessing the state plan benefits must occur before accessing this service. All items shall meet applicable standards of manufacture, design and installation. The medical support devices or equipment must have proven evidenced-based support and conform with acceptable medical practice; no experimental or alternative devises or equipment are permitted to be purchased. Any devices used in the provision of the service must be FDA approved. Specialized Medical Equipment and Supplies must be authorized by the Service Coordinator as part of the Individual Service Plan process. Specialized medical equipment and supplies must be purchased through a

self-directed budget through the Fiscal Intermediary.

-- -

Rev 9/29/2014 Page 20

l /;

*Waiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limits Rates*

*Code with Provider Provider Able to*

*Choice Provide*

***Service?***

Adult 5734 Vehicle No Yes Yes Yes Adaptations or alterations to an automobile or van that is Cost not to exceed $15,000

Supports, Modification the waiver participant's primary means of transportation over a five year period. Community in order to accommodate the special needs of the Modifications can only be Living & participant. Vehicle adaptations are specified by the · made to the individual's car Intensive service plan as necessary to enable the participant to or the car of a family member Supports integrate more fully into the community and to ensure the used to transport the

health, welfare and safety of the participant. individual. Vehicle

Examples of vehicle adaptations include: modification is not available to individuals who reside in a

• Van lift provider residential setting or

• Tie downs in 24 self-directed 24 home

• Ramp sharing supports or in the

• Specialized seating equipment live-in caregiver model.

• Seating/safety restraint

The following are specifically excluded vehicle

modifications:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual.

2. Purchase or lease of a vehicle

3. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the adaptations.

The individual must be in the family home. Funding for adaptations to a new van or vehicle purchased/leased by family can be made available at the time of

purchase/lease to accommodate the special needs of the .

participant. This service must be an identified need and documented in the service plan. The Vehicle modifications must be purchased through a participant-

Rev9/29/2014 Page 21

l *)*

I

*Waiver Service Service Name Agency*

*Code with*

*Agency Relative' Service Definition Service Limits Rates*

*Provider Able to*

*Choice Prm>ide*

|  |  |  |
| --- | --- | --- |
| *Individual* | |  |
| *Provider* |  | |

***Service?***

directed budget and paid through the Fiscal Intermediary

1. The Service Coordinator must receive in advance for his/her review and recommendation the following information: a proposal detailing the request for funding and the completed Vehicle/Home Adaptations Funding Request Form. The participant's Individual Support Plan that clearly defines and explains the need for a vehicle adaptation must be attached to this information.

2. If the DDS Service Coordinator recommends the proposal for funding, the request is then forwarded to the Area and then the Regional Director for review and recommendation of funding.

3. All payments for Vehicle Adaptations must be made through the Fiscal Management Service and purchased through a self -directed budget.

Community 5719 Live-In No Yes No No The payment for the additional costs of rent and food that The live-in caregiver may not Maximum Living& Caregiver can reasonably be attributed to a live-in personal be related by blood or daily rate is Intensive caregiver who resides in the same household as the marriage to any degree. The determined Supports waiver participant. Payments for live-in caregiver live-in caregiver cannot be from a rate

services are made to the waiver participant. Payment will employed by a provider of sheet based not be made when the participant lives in the caregiver's waiver services. Live-in upon

home or in a residence that is owned or leased by the caregiver cannot provide town/city the provider of Medicaid services. The live-in caregiver may more than 40 hours of direct individual provide up to 40 hours per week of direct service service per week. lives. including self-directed adult companion, self-directed

individualized home support self-directed individual supported employment or individualized day support. The live-in caregiver service must be self-directed, paid through the Fiscal Intermediary.

Rev 9/29/2014 Page 22

*l) (*

\\_ /

*Rates*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Waiver* | *Service* | *Service Name* | *Agency* | *Individual* | *Agency* |  | *Relative'* | *Service Definition* | *Service Limits* |
|  | *Code* |  | *witfl* | *Provider* | *Provider* |  | *Able to* |  |  |
|  |  |  | *Cfloice* |  |  |  | *Provide* |  |  |
|  |  |  |  |  |  |  | *Service?* |  |  |
| Intensive | 5156 | 24 Hour Self- | No | Yes | No |  | Yes | 24-Hour Self-Directed Home Sharing Support consists of | This service may not be |
| Supports | 5157 | Directed |  |  |  |  |  | ongoing services and supports by paid care giver(s) that | provided at the same time as |
|  | 5158 | Home Sharing |  |  |  |  |  | is designed to assist individuals to acquire, maintain, or  improve the skills necessary to live in a non-institutional setting. The service is available to individuals who need daily staff intervention with care, supervision and skills | Respite, Individualized Home  Supports, or Adult Companion or when other services that include care and |
|  |  |  |  |  |  |  |  | training in activities of daily living, home management  and community integration and live in a home of their own or live in the home of a care provider identified by the waiver participant or the legally responsible individual. . The care provider is identified and supervised directly by the waiver participant or the legally responsible individual. Unlike Placement Services in Residential Habilitation, there is no support agency involved in the 24-Hour Self-Directed Home Sharing Support. Like placement services there is an assessment to determine the intensity of the need of the individual in relation to the daily payment rate for the care provider. There are three levels of intensity in the model. 24-Hour Self-Directed Home Sharing S\lpport means individually tailored supports that assist with the  acquisition, retention, or improvement in skills related to  living in the community. These supports include adaptive skill development, recognition and money management, | supervision are provided 24-  Hour Self-Directed Home Sharing Support services are not available to individuals who live with their parent or spouse unless that individual is also eligible for the Department's supports. Family members who are either the legal guardian or legal representative or spouse cannot provide 24-Hour Self- Directed Home Sharing Support. Other family members such as siblings or cousins, aunts, uncles may provide these services. 24- Hour Self-Directed Home |
|  |  |  |  |  |  |  |  | social and leisure skill development that assist the  participant to reside in the most integrated setting appropriate to his/her needs. 24-Hour Self-Directed Home Sharing Support also includes personal care and protective oversight and supervision 24 hours a day. This service may also include the provision of medical and health care services that are integral to meeting the daily needs of the participants or arranging and assisting | Sharing Support cannot be  provided in a provider licensed Group Residence or staffed by a provider agency. The physical site is either owned or leased directly by the waiver participant or the direct care provider and not |

Daily rate ranges:

5156: $110-

$138.90

5157:

$125.93-

$196.92

5158:

$164.57-

$251.27

Rev 9/29/2014 Page 23

\\_ (*)*

*(*

*Waiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limits Rates*

*Code with Provider Provider Able to*

*Choice Provide*

***Service?***

individuals to access the health care system. by the provider agency. 24- Transportation between the participant's place of Hour Self-Directed Home residence and other service sites or places in the Sharing Support is limited to community may be provided as a component of 24-Hour one individual in the same Self-Directed Home Sharing Support and is included in site. Licensed providers may the individual's participant budget. 24-Hour Self- not act as the employer of the Directed Home Sharing Support must be purchased care provider and may not through a self-directed budget. These services may be provide services in one of arranged and organized by a family member or legally their licensed settings. responsible individual.. Payment is not made for the cost

of room and board including the cost of building maintenance, upkeep and improvements. 24-Hour Self- Directed Home Sharing Support services can only be self-directed through an individual budget and paid through a fiscal management service.

Intensive 5284 Transitional No Yes Yes Yes Transitional Assistance Services are non-recurring set-up Transitional assistance

Supports Assistance expenses for individuals who are transitioning from an services do not include institutional or another provider-operated living monthly rental or mortgage arrangement to a living arrangement in a private expense; food, regular utility

residence whether or not the person is directly charges; and/or household responsible for his or her own living expenses. Allowable appliances or items that are

expenses are those necessary to enable a person to intended for purely establish a basic household that do not constitute room diversional/recreational

arid board and may include: (a) security deposits that are purposes. Transitional required to obtain a lease on an apartment or home; (b) Services are furnished only to

essential household furnishings and moving expense the extent that they are required to occupy and use a community domicile, reasonable and necessary as including furniture, window coverings, food preparation determined through the

items, and bed/bath linens; (c) set-up fees or deposits for service plan development utility or service access, including telephone, electricity, process, clearly identified in

heating and water; (d) services necessary for the the service plan and the

individual's health and safety such as pest eradication person is unable to meet such i

Rev9/29/2014 Page 24

I"\_./\ (

*Waiver Service Service Name Agency Individual Agency Relative' Service Definition Service Limits Rates*

*Code with Provider Provider Able to*

*Choice Provide*

***Service?***

and one-time cleaning prior to occupancy and; (e) expense or when the services activities to assess need, arrange for and procure needed cannot be obtained from other resources. This service may be self-directed paid through sources.

the Fiscal Intermediary.

; Relative is defmed as not a legal guardian or legal representative.

Rev 9/29/2014 Page 25

(\_;

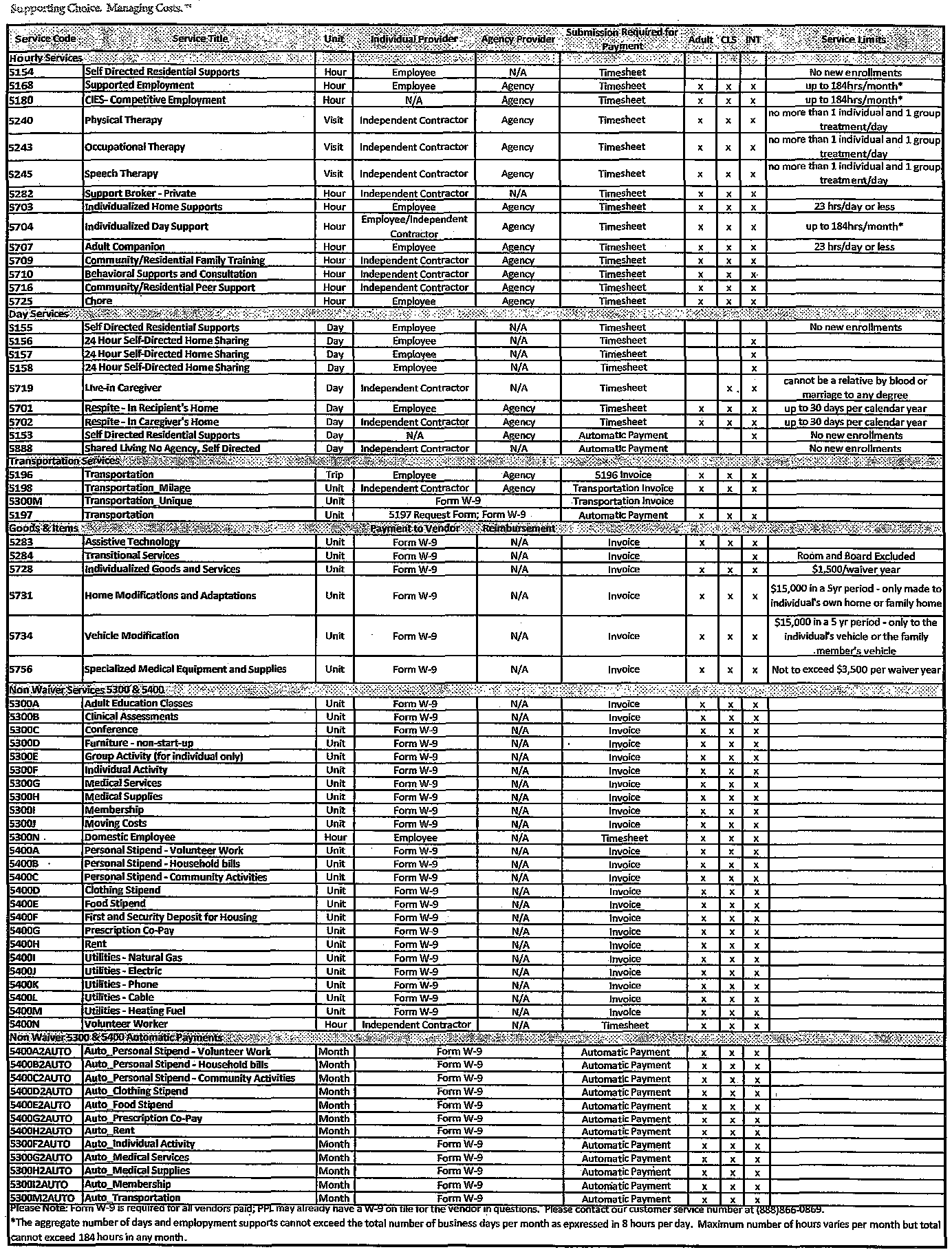
*Public*

PCG

*Partnerships*

**MA Participant Direct Program**

**Required Packets Forms Per Service**



Updated 8/U/14

*(*

'"'- -

*Public* .

*Partnersl11ps*

PeG

"''1"'·-t": (·!,.,,...\_.\_ ,\1.:;:·- "'!tt'••·l-

MA Participant Directed Program New Provider Paperwork Matrix Welcome to the Massachusetts Participant Directed Program! In order to begin providing services through the program,certain paperwork must be completed and submitted to PPL for processing. Once all required

paperwork has been fully and accurately completed,you are good to begin working. Depending on the provider

type that you have selected to work under (Independent Contractor, Employee, or Agency), the required paperwork may vary. In order to assist with the on-boarding process of new providers, the below matrix has been created to outline all required paperwork for each required provider type in the program.

How to read the chart below:

The first column on the left is a Jist of all possible pieces of paperwork The first row on the top is a list of the four provider types. Find your provider type in the top row:Employee,Independent Contractor, Agency,or 'Non­ Waiver Service' Provider. Look down the appropriate column. Any cell with an 'x' in it means thatthe corresponding piece of paperwork in the 'paperwork column' is required.

Two Important Notes:

1. All Provider packets and CORI application are located on [www.publicpartnerships.com.](http://www.publicpartnerships.com/)

2.Please note: Any participant receiving IP services must have an Employer of Record on file. An EoR is established by filling out an Employer of Record packet on publicpartnerships.com

Please refer to the chart,below to determine what paperwork is required for 'good to go' status for new providers:

|  |  |  |  |
| --- | --- | --- | --- |
| New Employee | New Independent Contractor | New Agency | New'Non- Waiver Service' Provider |
|  | | | |

*,, /*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employee Packet: | | | | |
| FormA | X . |  |  |  |
| Form B | X |  |  |  |
| Employee Info.Form | X |  |  |  |
| INS Form 1-9 | X |  |  |  |
| IRSW-4 Form | X |  |  |  |
| A DOR Form M-4 | X |  |  |  |
| EFT Form (optional) | X |  |  |  |
|  |  |  |  |  |
| Independent Contractor Packet: | | | | |
| IRS W-9 Form |  | X |  |  |
| IC Info.Form |  | X |  |  |
| FormA |  | X |  |  |
| Form B |  | X |  |  |
| EFT Form {optional) |  | X |  |  |
|  |  |  |  |
| Agency Packet: | | | | |
| IRS W-9Form |  |  | X | X |
| Agency Info.Form |  |  | X |  |
| FormA |  |  | X |  |
| Form B |  |  | X |  |
| EFT Form (optional) |  |  | X |  |
|  |  |  |  |  |
| Credentialing Packet\*: | | | | |
| Information Form | X | X | X |  |
| Service Selection | X | X | X |  |
| Certification Page | X | X | X |  |
|  |  |  |  |  |
| CORIApplication: | | | | |
| CORI Reouest lx lx I I | | | | |

\*The Credentialing Packet is obtained by creating a provider profile in the Web Portaland clicking "print forms" at the bottom of the last page

\...\_.. / Please call**PPL** CUstomer Service at:(888) 866-0869 with any questions

.,

*,*

*( )*

i '

*()*

**Sample Budget**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Budget | $21,292.00 |  | | | |
| TotalAllocated Funds: | $21,()92.00 | TotalAuthorizations: | $21,092.00 | StartDate: | 71112013 |
| TotalUnallocatedFunds: | $200.00 | TotalSpent: | $20,754.90 | EndDale: | 6/3012014 |
| TotalBudgBalancG: | $531.20 | TotalAuthorizations Balance: | $337.20 |  |  |

5400: Non waiVer financial \\

5400H2AUTO:

Auto\_Rentli\

5703: 1!1dMdual ed Date

Homesupports1\

5400C:Personal Oate

Slipend.

Communltyq

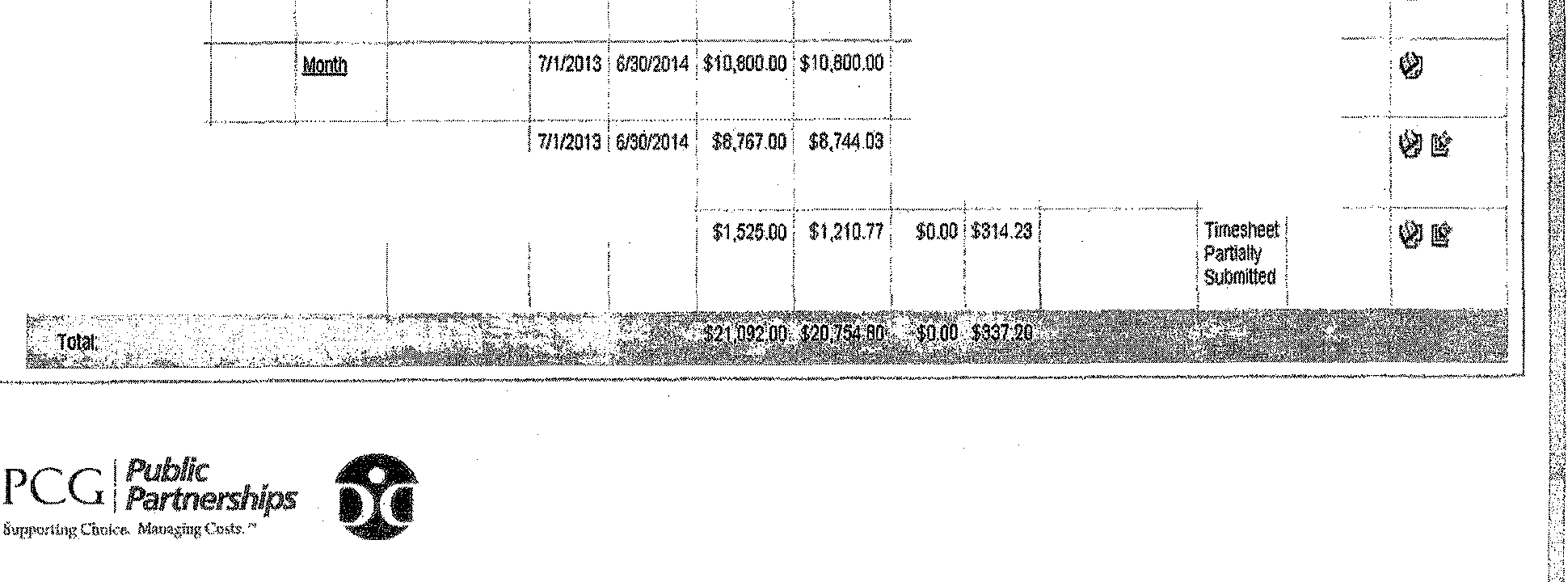
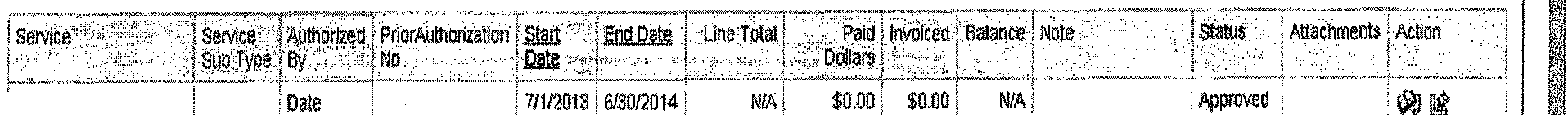
71112013 [ 6/3012014

$0.00 $0.00 Paid

$0.00 $22.97 ; Timesneet ; Partlally ! S!Jbmitred !

'

.. ...............



11

,- */-,*

l

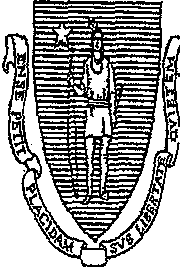
*(*

*)*

I :

-- *The Commonwealth of Massachusetts*

*(*



CHARlES D.BAKER

**GOVERNOR**

KARYN E. POLITO UoUToNANT GOVERNOR

Executive Office of Health & Human Services Department of Developmental Services Metro North Area Office

27 Water Street

Wakefieid,Mass. 01880

lEL 781-338-2300• FAX 781-338-23020 TlY 781-338-2332

ELINM.HOWE

COMMISSIONER

AMANDA J.CHALMERS

REGIONAL DIRECTOR

MARYLOU SUDDERS

SECRETARY

February *5,*2015

LYNNFIELD,MA 01940

Dear·

RiCHARD A.KAUSH

**AREA DIRECT-oR**

I

I

rr-l:ere is a copy of your new ISP which you and your ISP Team developed for this year. Also included is a Support ' '

;

''-.greement that tells about the services and supports to help you meet your goals.

Also enclosed is an ISP Response Sheet. 1f you are in agreement with the Plan as written, please sign yi>ur name and date this fonn within thirty (30) days of your receipt of this package and return it to me at the above address. The copy of the Plan is for your records.

If you have concerns about or would like clarification regarding the information included in the ISP, please feel free to call me at the Area Office within ten (10) days of your receipt of this letter.

If you Want to make a formal appeal of your ISP, you must send this appeal to the.DDS Regional

Director at:

Amanda Chalmers

POBoxA Hathorne, MA 01937 (978)7:74-5000

If you want or need help you have the right to have a lawyer or an advocate help you with the appeal.

You can get a copy of the DDS regulations or ask questions about your right to appeal by taJJdng to the Hearings

Administrator. You can reach this person at the DDS Legal Office, *500* Hanison Avenue, Boston, MA 02118 or at{617)

727-5608, ext. 7707.

Sincerely,

i'i'"'Yice Coordinator

"CC:

APPEAL NOTIFICATION

',, I/we understand that the ISP will be implemented as written unless within 30 days I/we initiate an appeal on any of the foiiowing grounds, which may be found in 115 CMR 631 et seq. which are·summarized below:

1. eligibility for supports;

2. priority of need;

3. whether the assessments which served as the basis for the ISP were sufficient for that purpose;

. · 4. whether the goals identified in the ISP are consistent witb the following quality of lite areas:rights and digoity; individual control; community membership; relationships; personal growth and accomplishments; and personal well-being;

*5.* whether the type of support identified in the ISP is the least restrictive; appropriate and available support to

**meet the goals;**

6. whether behavior modification, medication and limitations of movement are consistent witb Department of

Developmental Services regulations;

7. whether the recommendation of the ISP team with regard to the individual's ability to make personal and

:financial decisions is consistent witb the clinical evidence available and whether the type of decision-making

support recommended is consistent with the standards set forth at 115 CMR 5.07;

8. whether the ISP was developed, reviewed or modified in accordance with tbe procedures set forth in the ISP ·

. regolations; and

*(1.*whether the ISP is being implemented.

\,....\_.

An appeal may be had at any time as to whetber·the ISP is being implemented. Ifwe want to appeal the ISP on tbe following grounds:

Date Individual

Guardian

Re:

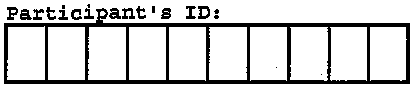
"/"'

''--

*(*

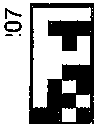
! *}*

• PUBLIC PARTNERSHIPS, LLC - M< r'DP • PROVIDER TIMESHEET •



*(!*

Participant's Name: --------------------



I I I I I

providerIs ID '

PUBLIC.

Provider's Name: ,PARTNERSHIPS "'

Service Code

, FAX TIMESHEETS ONLY TO PPL@ 877-779-4188

MAIL: PUBLIC PARTNERSHIPS, One Cabot rd. Ste. 102, Medford, MA 02155

I I I I I

I lweekl I Begin:Sunday(mm/dd/yy)rn *I* rn *I* rn I I lwe :k2 I End: Saturday (mm/dd/yy) rn *I* rn *I* [[) I

T im e IN AM/PM T ime OUT .AM/PM Total Hours Time IN AM/PM T im e OUT AM/PM Total Hours

AM PM

.

0 0

AM PM

.

.

0 0

AM PM AM PM

.

.

0 0 0 0

AM PM . AM PM AM PM AM PM .

Sun

Sun

0 0 . 0 0 0 0 . 0 0 .

.

0 0 . 0 0

0 0 0 0

Mon

AM PM

. AM PM

AM PM AM PM AM PM

Mon

. 0 0

0 0 . 0 0 . 0 0

"0"' P0M .

AM PM AM PM

0 0 0 0

Tue

AM PM AM PM . . AM PM AM PM

0 0

.

Tue

.

.

AM PM AM PM . AM PM

0 0 0 0 0 0

AM PM

0 0

AM PM AM PM . AM PM . AM PM

0 0 . 0 0 .

.

0 0 . 0 0

.

.

Wed

. AM PM .

PM .

Wed

. AM PM .

. 0 0 0 0 0 0

AM AM PM

0 0

AM PM PM AM PM AM PM

Thu

0 0 0 0

.

. . .

Thu

0 0 0 0

AM PM AM PM

0 0 0 0

AM PM AM PM

0 0 0 0

AM PM AM PM AM PM AM PM

. .

0 0

.

Fri 0 0 0 0 Fri 0 0

.

.

.

AM PM

0 0

""'PM

0 0

AM PM AM PM .

0 0 0 0

Sat

AM PM AM PM . AM PM AM PM .

. 0 0 0 0 sat 0 0 0 0

AM PM

.

.

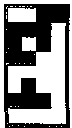
.

0 0

f>'M PM AM PM . AM PM

0 0 0 0 0 0

....



*By signing below, I certify services I have provided* to *the I certify that the participant has received hours* of *service as participant during the times described on this timesheet. reported* above.

Date (mm/dd/yy) : Provider Signature: Date (mm/dd/yy) : Participant/Responible Party Signature:

0 [DtDJt[I]I I ITJI[]]t[D I

•

"'

USE B L A C K INK, PRINT 0 N E CHARACTER PER BOX, F I L L C I R C L E S COMPLETELY, TRY NOT TO TOUCH THE LINES !!!

Per Medicaid regulations the MA PDP program does not allow payroll hours to exceed 40 hours per week. •

PUBLIC e

.nCh ckHere if this is" REIMBURSEMENT(seJ •;m oitant note• b;i.i. Ocheck Here ifthis ia PAYMENTTO VENDOR

!P·r1ovider

\."1 Name:

Provider Address: City, State, Zip:

. c;;ID · ..•1 ef I I I *\_l*

. :t6 IT I 11I I I I 1

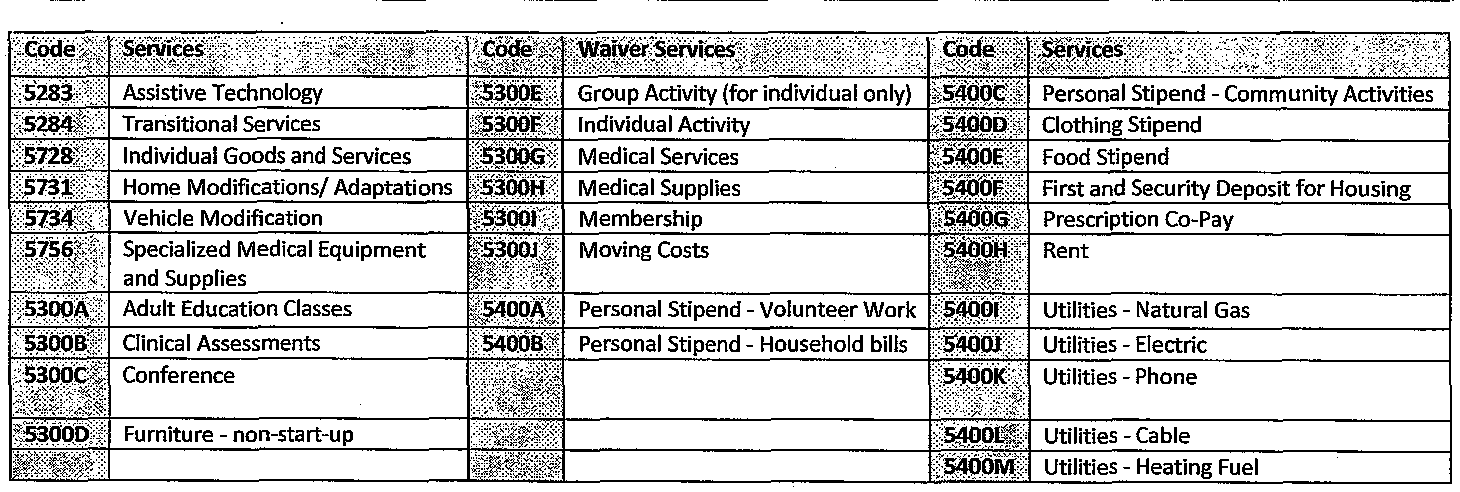
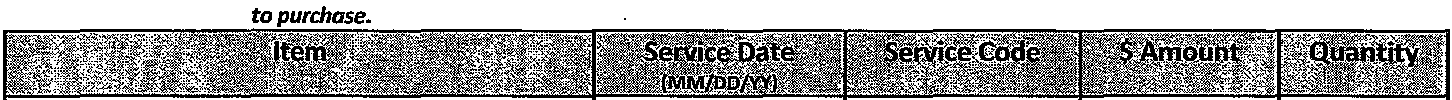
:IJ.C !!c :iiki:o Remittf:i ddfs List d'seiow' ' ' ,; I Participant First Name:

*.'{,'.* o•>,- :•; \_.,., -.-.. \_- ·.;.:\_,-, ,,., .:.;>>· • . ';\_\_,< ,•\\_ ,,;:\_.·";":!:'•

Remit Address:

I Participant Last Name:

Remit City, State, Zip: J ht::nxl xl I I I I I m



*Agency vendor. the Tax Identification number is the Federal Employer Identification Number {FEIN}.*

*Invoice Guidelines*

1. All invoices or payment requests must include a quote or receipt from the vendor as back up documentation accompanying this form.

2. Enter the service code that matches the service authorized in the budget.

3. Enter the total amount (including taxes) that the check will be made out for. If you have more than one service code on the quote or price check receipt, distribute the taxes evenly among the service codes. *NOTEII/ the in110ice exceeds certain dollar amounts,you must receive DDS approval prior*

1.

2.

*..r-""""* I 3.

Participant or Responsible Party Signature Printed Name Date

\*IMPORTANT NOTE: YOU MUST ATTACH A RECEIPT WITH THIS INVOICE FORM. FAILURE TO DO SO WILL RESULT IN A 1099 BEING ISSUED AT THE CLOSE OF THE YEAR\*

DDS Staff Person Initials:

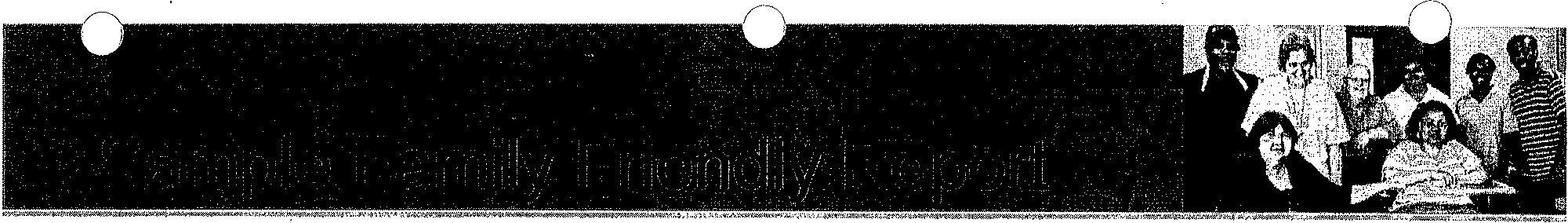
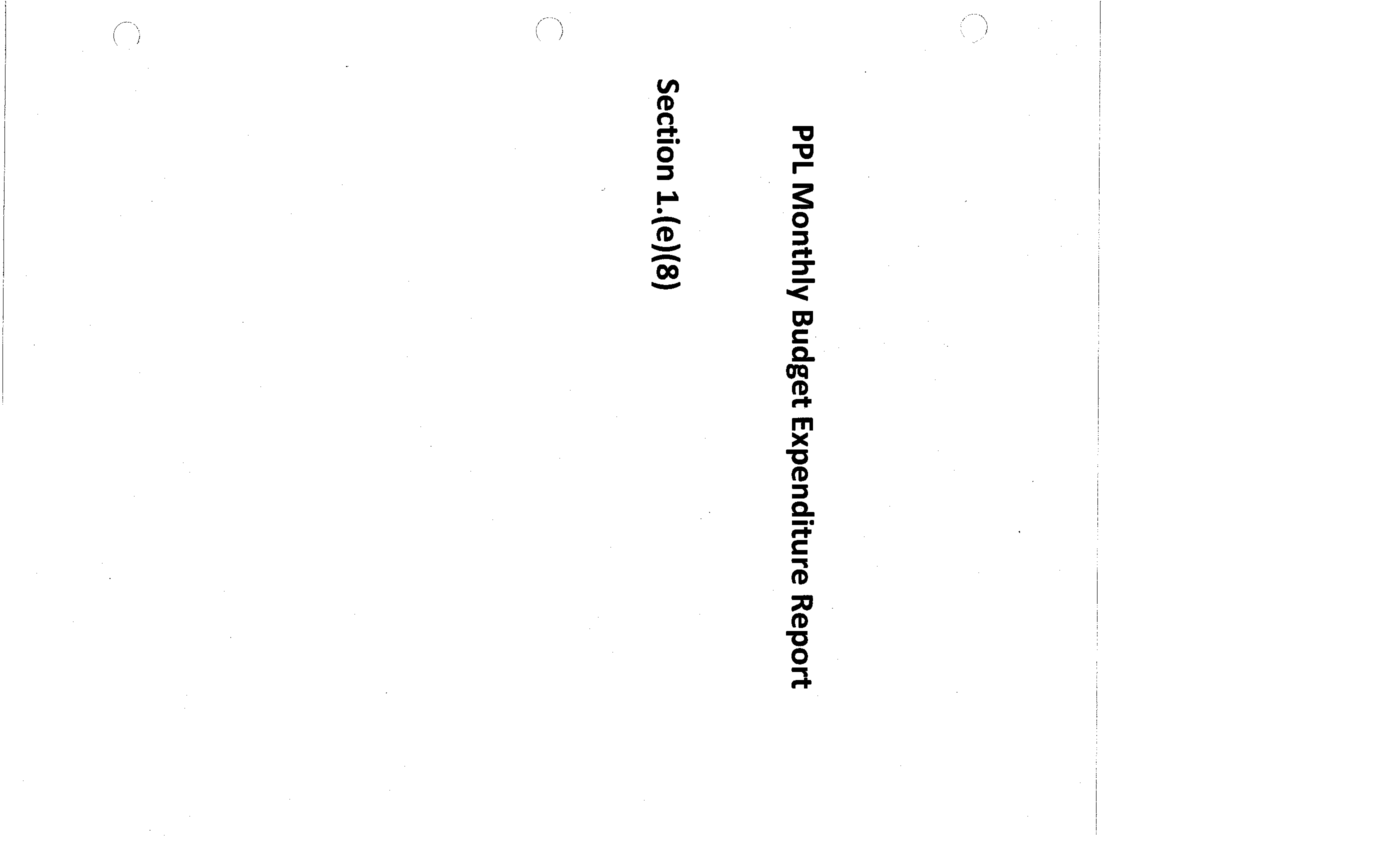
\ -

FAX OR MAIL INVOICE REQUEST WITH COPY OF QUOTE/PRICE CHECK RECEIPT TO:

FAX: 877-563-6438

MAIL: PPL, MA PDP Program ,One cabot rd. Ste. 102, Medford, MA, 02155

PlEASE KNOW THAT FAILURE TO FILL OUT THIS FORM COMPLETELY AND ACCURATELY CAN RESULT IN DELAY OF PAYMENT.



M" ue

,.f4:p

*(fr.,gl!'·,* M"<4 m;:

*.:.Itt, '!{{\*

Mwullly "tE-ndltiWO <>p<>lt

MAP(W

c-(;NS, Qt;

'&l'A Wf MT6; ACUVlt\t 1¥!AAf *!)J\'t :* ACftVHV QI OA"fl!

't'U.RQ

AAI'A.:.W.:ll;

*9-M:J.$* -fltUMU *ER::*

*CUI£$1: t*

1 i i!14

1 MJ4

1Jt)(m4.

M:4l &l>'t'W\_..:r

' ""'""'$$;

-H<>W'fOfll'fiW VJW *!M.OO'tm:V* ACCOiliJ'41' $Tf\T t:H1"

U!> & r,t.:::::.tt W>!-1' -"-IA:f'""-' .al.wi l(<o- ., -.!.¥""-!';t:\t!l!t&!A;>



$ilo!W(lll) t: .

llJ'4. - I)to1i}'O:O -v.: M M\t!lt!'"f'¢1" ;Mq: ,:lllf:Jl;l'<i1:

ilflf',} W•t,.t.:.A Q P£\* #:i':t"A>o},rt'- l.l l'-IMl .

---·-----·---·------·--------...,........-----

*lite¥.* lli'41iMolltWII#' M Qult OU.f Uft'4'tV 1¢ OJ..H

'1\t, .w;

•

Yq.W, , «. .ti;ti!W

: *t!!«,*

M;t:c.QJ!.#:Y , *:r. tieLrr X*

- ... ""'""' .\_...

*"'* '

.a:-

#.1#;:. - ·P• :H¢-P'l"' 'ti.



\_*"9!.-i!*.*U*.

..... itj@. .."'\*-"'l' ..,..

'\*· """'""'"' ""'.,;j; '>, !ff H- -".1. *'I,MJ:.-l't* WJ< "-""">

*e.;•.. .:.lt - .,.,-ll'ol: ·-...-* ... .. l ,;r.!; """'

l«'W·· --..tf!>...,;..-

*;p .;w;* """""

-.... lJinoM 11:11'1·



ft\"1>1! A(;f'Mf>r; .. . i V ft:.t ' \IM1! .UMH-Il4 *-*

<I;

16



"

.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| RFR QuaiUf!catiolnllist: SIDQUAL-.10-AWC  Date: 8/3/201() | Location Availability | | | | | |
| Northeast | Southeast | Metro | Central | West | |
| Agency With Choice Qualified Providers |  |  |  |  |  | |
| Advocates, Inc. | X | X | X | X |  | |
| Anodyne Medical Services Corp. | X | X | X |  |  | |
| ARC Community Services, Inc. |  |  |  | X |  |  |
| ARC of Cape Cod |  | X |  |  |  |  |
| ARC of Greater Havemill Newburyport | X |  |  |  |  |  |
| ARC of Greater Plymouth |  | X |  |  |  | |
| Association for Community Living |  |  |  |  | X | |
| Bay Cove Human Services | X | X | X |  | '  I | |
| Beaverbrook STEP | X | X | X | X |  | |
| Behavioral HeaHh Network, Inc. |  |  |  |  | X | |
| Berkshire County Arc, Inc. |  |  |  |  | X | |
| Berkshire Family and Individual Resourses |  |  |  |  | X | |
| Better Community Living |  | X |  |  |  | |
| Brockton Area Multi-Services | X | X | X | X |  | |
| Cambridge Family and Children's Service | X |  | X |  |  | |
| Career Resources Corp. | X |  |  |  |  | |
| Centro Las Americas |  |  |  | X |  | |
| Charles River Association |  |  | X |  |  | |
| Community Connections |  | X |  |  |  | |
| Cooperative for Human Services, INC | X |  | X |  |  | |
| Cooperative Productions, Inc. |  | X |  |  |  | |
| Delta Projects |  | X | X |  |  | |
| East Middlesex ARC | X |  |  |  |  | |
| Eliot Community Human Services, Inc. | X | X | X |  |  | |
| Enable, Inc. |  | X | X |  |  | |
| Fidelny House Human Services | X |  |  |  |  | |
| Friendship Home,Inc. |  | X |  |  |  | |
| Greater Marlboro Programs Inc |  |  | X |  |  | |
| Habilitation Assistance Corporation |  | X |  |  |  | |
| Horace Mann Educational Associates ' |  | X | X | X |  | |
| Jewish Family and Children's Service |  |  | X |  |  | |
| Kennedy Donovan Center |  | X | X. | X |  | |
| LileLinks, Inc. | X |  |  |  |  | |
| LifeStream, Inc. |  | X |  |  |  | |
| Lifeworks,Inc. |  | X | X |  |  | |
| M.O.Ufe |  | X |  |  |  | |
| Martin Luther King Jr. Family Services |  |  |  | X | X | |
| Matson Community Services, Inc. |  |  |  | X |  | |
| Multicultural Community Services of the Pioneer Valley, Inc. | |  |  |  | X | |
| North Suffolk Mental Health Association | X |  | X |  |  | |
| Northeast ARC | X |  |  |  |  | |
| NWW Committee for Community Living |  |  | X |  |  | |
| People, Incorporated |  | X | ------- | -- |  | |
|  |  |  |

'

*( -*

.

*-.*

''- - -

*(*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Project COPE, Inc. | X |  |  |  |  |
| Public Partnerships | X | X | X | X | X • |
| Reach, Inc. |  | X |  |  |  |
| Resources for Human Development, Inc. | X | X | X |  |  |
| Riverside Community Care | X |  | X | X |  |
| ServiceNet |  |  |  |  | X I |
| Seven Hills Community Services . | X | X | X | X | X I |
| Seven Hills Family Services | X | X | X | X | X |
| South Norfolk County Association for ARC, Inc. |  | X | X |  | I |
| South Shore Support Services |  | X |  |  |  |
| Southeastern Massachusetts Educational Collaborative |  | X |  |  |  |
| Southern Worcester County ARC |  |  |  | X | I |
| The Arc of Northern Bristol County |  | X | X |  |  |
| The Barry L. Price Rehabilitation Center, Inc. |  |  | X |  |  |
| The Bridge of Central Massachusetts, Inc |  |  | X | X |  |
| The Edinburg Center | X |  | X |  |  |
| The Nemasket Group, Inc. |  | X |  |  |  |
| The Shared Living Collaborative | X |  |  |  |  |
| Toward Independent Living and Learning, Inc. | X | X | X | X |  |
| 1 UCP of Berkshire County Inc |  |  |  |  | X |
| UCP of Metro Boston | X |  | X |  |  |
| UnHed ARC of Franklin and Hampshire Counties |  |  |  |  | X |
| Vinfen | X | X | X |  |  |
| Walnut Street Center, Inc. | X |  | X |  |  |
| Waltham CommHtee, Inc, dba WCI-Work Community, Inc | X | X | X | X |  |
| Work, Inc | X | X | X |  |  |

i:

'--

Please Note: Proposal Reviews are still ongoing; additional qualifying providers will be added in the coming days.

*('·*

:

PARTNERSHIPS CORI REQUEST

PUBLIC **8**

*(*

FAX COVER PAGE

One Cabot rd. STE I 02

Medford, MA 02155

Tel: 888-866-0869 Fax:

l-877-563-6438

*TO:*  MA PDP Program

PUBLIC PARTNERSHIPS, LLC

*FAX NUMBER:* 1-877-563-6438

---------------- -------

*PHONENUMBER: -----------------------­ FROM:* EMPLOYEE APPLICANT

*DATE:*

*RE:* CRIMINAL BACKGROUND CHECK

*NUMBER OF* 3

*PAGES*

*(including cover)* -----------

*COMMENTS:* 0 *Urgent* ***For your review*** I:ZJ *Reply ASAP* **D *Please Comment***

*(*

'- REQUIRED INFORMATION

LAST NAME OF DDS CONSUMER:

, FIRST NAME OF DDS CONSUMER:

TYPE OF GOVERNMENT ISSUED PICTURE ID INCLUDED: BREIF DESCRIPTION OF POTENTIAL JOB:

,/"" '

**Confidentiality Notice**

**The Documents accompanying this transmission contain coti.fidential information intended for a specific individual and purpose. The information is private and is legally protected by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the talcing of any action in relation to the contents of this telecopied information is strictly prohibited.**

**\_CORITransmittalPage.doc**

*(.*

"--

COR! REQUEST FORM

Please send all completed CORIApplications by fax to Public Partnerships,LLC (PPL): 1-877-563-6438

PUBPA EOHHS

Public Partnerships, LLC has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As an applicant'employee for I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

Applicant'Employee Signature

APPLICANT/EMPLOYEE INFORMATION (PLEASE PRINT)

LAST NAME

FIRST NAME MIDDLE NAME

MAIDEN NAME OR ALIAS (IF APPLICABLE) PLACE OF BIRTH

DATE OF BIRTH SOCIAL SECURITY NUMBER (Requested, not required)

*(*

I

\*ID Theft Index PIN (if applicable)

'-- MOTHER'S MAIDEN NAME

CURRENT AND FORMER ADDRESSES:

SEX: HEIGHT:

ft.

in. WEIGHT:---- EYE COLOR: \_

STATE DRIVER'S LICENSE NUMBER:-------------- (include state of issue)

\*\*\*THE INFORMATION WAS VERIFIED WITH THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION:-------

REQUESTED BY: SIGNATURE OF CORI AUTHORIZED EMPLOYEE

\*The CHSB Identify Theft Index PIN Number is to be completed by those applicants that have been issued an Identity Theft Index PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process.

All CORI request forms that include this field are required to be submitted to:

I PPL by fax:1-877-563-6438