CHOICE MANUAL

Revised November 2007

Prepared by the Division of Aging

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10000 Overview of CHOICE

The Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program provides case management services, assessment, and in-home and community services to individuals who are at least 60 years of age or persons of any age who have a disability due to a mental or physical impairment and who are found to be at risk of losing their independence.

The CHOICE board has a range of oversight responsibilities as described in IC 12-10-11 and IC 12-10-10-11(b).

The Indiana Family and Social Services Administration (FSSA), Division of Aging (DA) establishes CHOICE guidelines and procedures for the effective management of the CHOICE program and provides a process for public input. The FSSA DA is responsible for publishing CHOICE guidelines and procedures as part of the FSSA DA Operations Manual (which are contained in this Section). Comments and recommendations specific to these guidelines are accepted annually from the public.

The FSSA DA provides notice to the public of revisions in guidelines and procedures by publishing any revisions of CHOICE guidelines and procedures in the CHOICE Board meeting agenda and posting revisions of CHOICE guidelines and procedures before an official CHOICE Board meeting in the office of the FSSA DA. Comments and recommendations for revision may be given during any official CHOICE board meeting.

At least 20% of the AAA CHOICE service dollars shall be utilized for individuals under the age of 60 with disabilities.

10001 Code of Ethics

All CHOICE providers or agents (including AAAs and CHOICE service providers) shall abide by the code of ethics in this section
(Authority IC 12-10-10, 460 IAC 1.2-2.1, 460 IAC 1-4-11)

A provider shall do the following:

(A) Provide professional services with objectivity and respect for the independence, needs, and values of the individual receiving services.

(B) Avoid discrimination on the basis of factors that are irrelevant to the provision of services, including, but not limited to race, creed, gender, age, or disability.

(C) Provide sufficient objective information to enable an individual or the individual's guardian to make informed decisions.

(D) Accurately present the professional qualifications and credentials of the provider and of all employees and agents.

(E) Require all employees or agents to assume responsibility and accountability for personal and professional competence in the practice of the person's profession and provision of services under this article.

(F) Require professional, licensed, or accredited employees or agents to adhere to acceptable standards for the employee's or agent's area of professional practice.

(G) Require all employees or agents to do the following:

i Maintain the confidentiality of individual information consistent with the standards of this article and all other laws and regulations governing confidentiality of individual information, including the Health Insurance Portability and Accountability Act (HIPAA).

ii Conduct all practice with honesty, integrity, and fairness.

iii Fulfill professional commitments in good faith.

iv Inform the public and colleagues of services only by use of factual information.

v Refrain from the following:

(a) Advertising or marketing services in a misleading manner.

(b) Engaging in uninvited solicitation of potential individuals who are vulnerable to undue influence, manipulation, or coercion.

(H) Make reasonable efforts to avoid bias in any kind of professional evaluation.

(I) Notify the proper authority of any unprofessional conduct that may cause harm or undue influence toward a participant. This may include FSSA DA, Indiana State Department of Health, licensing authorities, accrediting agencies, employers, or the State of Indiana Attorney General.

10002 AAA Contracts for Administration of CHOICE Funds

The FSSA DA contracts with the AAAs to administer CHOICE funds (Authority IC 12-10-10, 460 IAC 1-4-3, 460 IAC 1-4-11)

(1) The FSSA DA enters into contracts with AAAs for the purpose of administering CHOICE funds. Contracts are effective for a period of two (2) years.

(2) Contracted activities include **but are not** limited to:

(A) budgeting;

(B) case management;

(C) oversight;

(D) monitoring;

(E) reporting;

(F) quality assurance; and

(G) submission of fiscal claims to the FSSA DA.

10003 Public Records Requests

As a public agency, each AAA shall make public records available in accordance with Indiana's Public Access Laws (Authority IC-5-14-3).

The AAA shall ensure the provisions of IC-5-14-3, as well as HIPAA requirements regarding Protected Health Information (PHI) are followed when disclosing or making public records available.

10004 CHOICE Eligibility Determinations

Individuals must meet specified eligibility requirements in order to participate in CHOICE. (Authority IC 12-10-10, 460 IAC 1-4-1,460 IAC 1-4-5, 460 IAC 1-4-7(d) and (e), 460 IAC 1-4-11)

(1) The CHOICE case manager shall conduct an eligibility determination for individuals requesting services funded by CHOICE. In order to be eligible for CHOICE funds an individual must:

(A) Be at least sixty (60) years of age or disabled.

i Age shall be verified as recorded on a birth certificate, driver's license, passport or other official government document. Case manager shall document in case notes that age was verified using these documents;

ii "Disabled" refers to an individual with a severe chronic disability that is attributable to a mental or physical impairment or combination of mental and physical impairments that is likely to continue indefinitely;

(B) Be an individual at risk of losing their independence.

i "Individual at risk of losing their independence" means the individual is unable to perform two (2) or more activities of daily living as determined

through the use of an assessment.

- The long-term care services eligibility screen developed by the division shall be used by the case manager to assess the applicant's risk of losing his or her independence and to assist in the development of a plan of care if appropriate.

(C) Have assets that do not exceed five hundred thousand dollars ($500,000). If applicant wishes to receive services but has assets in excess of five hundred thousand dollars ($500,000), applicant may continue to receive services, but obligation for payment is solely upon the client.

i For applicants who have had a Medicaid determination within ninety (90) days of application for CHOICE, the case manager shall obtain asset information submitted to the Department of Family Services as part of the Medicaid eligibility determination process, from the FSSA DA CHOICE representative.

(a) The FSSA DA CHOICE representative shall provide the countable resource amount for each of the following assets (resources) obtained from the ICES system:

- Checking and Savings Accounts
- Certificates of Deposit
- Individual Retirement Accounts (except MED Works)
- Stocks/Bonds/Mutual Funds
- Cash surrender value of life insurance (CSV)
- Vehicles
- Non-income-producing Real Estate

ii For applicants who have **not** had a Medicaid eligibility determination within ninety (90) days of application for CHOICE, the case manager shall:

(a) Assist the applicant with gathering and completion of information necessary for the applicant to submit a Request for Assistance (for Medicaid) to the DFS; and

(b) Ensure the applicant has made application for Medicaid assistance prior to authorizing interim CHOICE services pending completion of the Medicaid eligibility determination as described in Section 12 of the Division of Aging Operations Manual.

(c) Upon completion of the Medicaid eligibility determination, the case manager shall obtain asset information from the FSSA DA CHOICE representative as described in (C)(i) above.

iii The CHOICE applicant must complete and sign the CHOICE Asset Attestation Form (Attachment 1) attesting that the information obtained from the Medicaid eligibility determination process continues to accurately reflect their assets, including type and amount.

(a) If the applicant’s assets have changed, the case manager shall refer

the applicant to DFS for a Medicaid eligibility redetermination.

iv If the applicant has assets in excess of $500,000, the case manager shall:

(a) Inform the applicant of their obligation to assume responsibility for payment of CHOICE service costs; and

(b) Determine if the applicant wishes to continue to receive CHOICE services.

v If the individual wishes to receive, or continue to receive, CHOICE services, the case manager shall ensure the individual is billed for 100% of the cost of CHOICE services in accordance with CHOICE billing procedures.

vi If the individual does not wish to receive, or continue to receive, CHOICE services, the case manager shall determine whether access to CHOICE services is essential to the individual's health and welfare.

(a) If the case manager believes lack of access to CHOICE services **places the individual at risk of neglect or harm**, the case manager shall:

- File an incident report documenting the circumstances; and
- Take no further action in regard to CHOICE services until the FSSA DA CHOICE representative makes a determination regarding how to proceed.
- The FSSA DA CHOICE representative shall make this determination within three (3) business days of notification by the case manager and shall notify the AAA in writing of their determination.

(b) If the case manager believes lack of access to CHOICE services **does not** place the individual at risk of neglect or harm, the case manager shall:

- Not authorize the individual to receive CHOICE services or shall ensure CHOICE services are terminated, as appropriate.

(E) Children's CHOICE

1) If the child meets the following eligibility requirements and is receiving qualifying services, record up to $2,000 in total annual expenditures for the child as Children's CHOICE/TANF. Eligibility for Children's CHOICE/TANF is limited to children:

- Who are eighteen years of age or younger and receiving CHOICE services.
- Whose family* income is below 250% of the federal poverty level (FPL). *There has to be a family relationship between the child and the caretaker relative and that caretaker could be a parent, a grandparent, aunt, uncle, older sibling or the spouse of one of

these relatives.

2) Qualifying services are limited to the following services:

- information and assistance;
- outreach;
- parent education; and
- specialized child care for working parents.

3) The total amount that may be allocated to Children's CHOICE/TANF is $2,000 per family.

- Record non-qualifying expenditures (e.g. for services other than those identified in (2) as Children's CHOICE (state-funded program).
- When a child has accumulated over $2,000 for qualifying services, record the expenditures in excess of $2,000 as Children's CHOICE (state-funded program).
- If the child does not meet the eligibility requirements for Children's CHOICE/TANF, expenditures could be recorded under CHOICE as Children's CHOICE (State-funded program).

4) CHOICE assessments are to be completed by a case manager within fourteen (14) calendar days of referral, within availability of funds for the assessment. Before each assessment, an explanation of the following must be given to the applicant by the case manager:

a. The purpose of the CHOICE assessment.
b. The applicant's right to decide at any time to stop the process, and to refuse the offered in-home and community services.
c. The applicant's right to appeal AAA decisions. See Section 100016 for more information regarding appeals.

5) Every applicant is eligible for an assessment for CHOICE and shall not be charged a fee for assessments.

The Long Term Care Services Assessment shall be offered to current nursing home residents who apply for CHOICE. Funds may be used for assessment for current residents in institutions who could return to their homes if determined to be eligible for the CHOICE program.

6) The use by or on behalf of the individual of any of the following services or devices does not make the individual ineligible for CHOICE funded services:

a. Skilled nursing assistance.
b. Supervised community and home care services, including skilled nursing supervision.
c. Adaptive medical equipment and devices.
d. Adaptive non-medical equipment and devices.

7) When a decision is made regarding CHOICE eligibility, the AAA shall notify the individual in writing whether or not the applicant is eligible for

the CHOICE program and, if eligible:

- that the applicant is approved for the development of a plan of care; or
- that, due to the lack of availability of funds, the applicant will be placed on a waiting list.
- If approved for the development of a plan of care, the portion, if any, of the individual's cost share obligation;
- That the applicant has the right to appeal this eligibility decision.

10005 CHOICE Waiting List

AAAs are responsible for ensuring there is no CHOICE waiting list whenever feasible and, when necessary, for maintaining the waiting list for their service area, submitting required data and reports regarding the waiting list and monitoring individuals who are on the waiting list.

(Authority IC 12-10-10, 460 IAC 1-4-3, 460 IAC 1-4-5, 460 IAC 1-4-11)

The CHOICE waitlist is comprised of individuals who have been assessed and are waiting for Choice services. Written protocol for a unified procedure to place patients on and off of the waitlist will be determined in the future.

10006 CHOICE Reduction in Service and Participant Termination Policy

CHOICE funding should be used after all other possible payment sources have been identified and all reasonable efforts have been employed to utilize those sources.

The AAA shall reduce services that are paid by CHOICE in any of the following circumstances:

1. An updated care plan reveals a diminished level of need.
2. CHOICE funds are insufficient to meet current participants and all reasonable efforts have been made to secure resources to avoid service reductions, the AAA has stopped performing new assessments and care plans, and the AAA has adopted a fair and equitable policy for distributing service reductions among participants.
3. An individual receiving services becomes eligible under a Medicaid home and community-based services waiver and begins receiving those services as allowable by Medicaid.
4. A current participant becomes eligible for in-home and community services from other sources that they were previously unqualified before.
5. Other resources in the community become available that were not available when the care plan was written.
6. Services needed by the individual are assessed and determined to be more costly than the cost per individual determined by the division.

The AAA shall terminate services that are paid by CHOICE in any of the following circumstances:

(1) The health, welfare, or safety of the participant or those they interact with can no longer be assured.

(2) The individual's health has significantly improved and services are no longer needed.

(3) Services being provided are detrimental to the participant's health.

(4) Fraudulent use of funded services by the participant or their CHOICE representative.

(5) Death of participant.

(6) Participant or CHOICE Representative's refusal to comply with cost sharing.

(7) Voluntary request for termination

(8) Refusal of services necessary for their health and well-being.

10007 CHOICE Cost-Sharing

AAAs are responsible for determining and implementing cost-sharing requirements for CHOICE. (Authority, IC 12-10-10, IC 12-10-11-8, 460 IAC 1-4-4, 460 IAC 1-4-8, 460 IAC 1-4-11)

(1) Cost-sharing is not required for:

(A) Participants who have a RID number.

(B) Participants whose income does not exceed one hundred fifty percent (150%) of the federal income poverty level.

(2) Cost sharing is required for participants with incomes over 150% FPL, unless the cost share of services would result in an income falling below 151% of the FPL. The participant is not obligated to pay the amount owed that would drop their income below this level.

(A) Participants with incomes over 150% FPL and up to 350% may be charged a share of cost depending on their amount of income adjusted by allowable deductions as specified in the Division of Aging Cost Share document.

- The cost share increases by ½ of 1% for each 1% increase in the percent of poverty over 150% FPL. The increase and corresponding dollar amount is also displayed in the Division of Aging Cost Share document.

(B) Participants with an income that exceeds three hundred fifty percent (350%) of the federal poverty level (FPL) adjusted by any allowable deductions as specified in Attachment 2, must pay **100% of the cost** of CHOICE services except for case management, the initial assessment and the development of the plan of care.

(C) The case manager shall determine the cost share amount by entering required income and service information into the FSSA DA data system. The data system automatically generates the cost share amount.

(3) The collection of each individual's monthly cost share is the responsibility of the AAA.

(A) If the cost share is equal to $9.99 or less annually, the AAA is not required to collect the cost-share from the individual.

(4) Cost Share Billing statements will be generated monthly and sent to the appropriate CHOICE individuals by the AAA.

(5) Cost share is not applied to case management, since this has been determined by the FSSA DA to be an administrative service and not a direct service.

10008 Individual Cap on CHOICE Funds

CHOICE funds are subject to an individual cap.
(Authority IC 12-10-10, 460 IAC 1-4-11)

(1) The FSSA DA has established a maximum level of expenditures of CHOICE funds per individual (cap).

(2) This cap is not to be applied monthly, but over a period of three (3) consecutive months to coincide with the period covered by the plan of care.

(A) The cost of home modifications can be amortized over a twelve month period.

(3) CHOICE case management is an administrative function of the AAA. It is excluded from the cost cap.

(4) The maximum level of expenditure will be calculated as a single cost amount for the elderly and for persons with disabilities under sixty years of age.

(A) This level of expenditure is calculated by the FSSA DA based on the Skilled Nursing Facility (SNF) Index, and is adjusted annually.

(B) The cap amount is provided to the AAAs by the FSSA DA on an annual basis.

10009 Funding of Last Resort

CHOICE funds may only be utilized after all other available sources of funding of home and community-based services (HCBS) have been accessed. **CHOICE funding shall be used only after all other possible payment sources have been identified and all reasonable efforts have been employed to utilize those sources.**
(Authority IC 12-10-10, 460 IAC 1-4-7, 460 IAC 1-4-11)

The AAA case manager shall conduct a review of all available sources of funding of home and community-based services other than CHOICE supports for each individual determined eligible for CHOICE funds. The review shall include, but is not limited to:

(A) Older Americans Act Funded HCBS such as Meals on Wheels, respite and adult day care services;

(B) Medicaid state plan HCBS such as home health services, durable medical

equipment (DME), non-emergency transportation, therapies, and targeted case management;

(C) Medicaid HCBS waiver services such as those included in the AD Waiver, TBI Waiver, and DD Waiver;

(D) Medicare services such as home health services and DME or special services provided by Medicare Advantage (HMO) plans;

(E) Services funded by the Ryan White Program;

(F) Services funded by the Vocational Rehabilitation Program;

(G) Food stamps;

(H) Services funded by the Veteran's Administration;

(I) Services funded by HUD; and

(J) Other sources of HCBS.

10010 CHOICE Funds and Medicaid

CHOICE funds may only be utilized **after** an applicant has been determined ineligible for Medicaid or if currently eligible for Medicaid, **after a determination that the requested service(s) is not available from Medicaid.**
(Authority, IC 12-10-10, 460 IAC 1-4-7, 460 IAC 1-4-11)

(1) CHOICE funds **may not be authorized** for any new client who has not applied for, or received, a Medicaid eligibility determination within the last ninety days.

(A) A new client who has not applied for Medicaid eligibility determination within ninety (90) days of application for CHOICE, the case manager shall:

i Assist the applicant with gathering and completion of information necessary for the applicant to submit a Request for Assistance (for Medicaid) to the DFS; and

ii Ensure the applicant has made application for Medicaid assistance prior to authorizing interim CHOICE services pending completion of Medicaid eligibility determination.

(B) CHOICE funds may be authorized for Medicaid applicants awaiting the outcome of a Medicaid eligibility determination.

(C) CHOICE funds and Medicaid spend down: If an eligible individual meets Medicaid asset guidelines but has a spend down provision to satisfy, CHOICE services may be utilized while the spend down amount is being met.

(2) CHOICE funds may be authorized for Medicaid recipients following a determination by the case manager and/or FSSA DA that Medicaid state plan services and HCBS waiver services for which the individual is eligible do not meet the identified need for which CHOICE funds are being requested.

(A) If the individual is a Medicaid recipient, the case manager must review whether the requested service is available or could be available under the Medicaid state

plan or under a HCBS waiver in which the individual is enrolled.

(B) If the requested service is denied by Medicaid (in the case of Medicaid state plan services) or by the HCBS waiver case manager or other HCBS waiver decision maker (in the case of HCBS waiver services**),** but an alternative service **is authorized,** the individual must access this Medicaid state plan or HCBS waiver alternative service.

(1) CHOICE funds cannot be used to fund alternative and/or more costly services or supports as an alternative to one that is available from another funding source because of individual preference, convenience or other factors unrelated to need. For example, CHOICE funds may not be authorized to purchase a specific type of van modification when a less costly van modification that can meet the individual's needs has been authorized from another funding source.

(2) If the individual refuses to access the authorized or available Medicaid state plan or HCBS waiver service, the case manager must issue a CHOICE denial and notice of right to appeal in accordance with Section 100016.

(C) If the requested service is denied by Medicaid (in the case of Medicaid state plan services) or by the HCBS waiver case manager or other HCBS waiver decision maker (in the case of HCBS waiver services), and an alternative service **is not authorized or available,** the service or support may be funded by CHOICE (subject to all other CHOICE funding restrictions.)

(3) CHOICE participants determined ineligible for Medicaid must reapply for a Medicaid eligibility determination each time their circumstances change in a manner that could affect eligibility (e.g. result in a determination they are eligible for Medicaid).

(A) The case manager shall assist the participant with gathering and completion of information necessary for the applicant to submit a Request for Assistance (for Medicaid) to the DFS and shall monitor the outcome of the Medicaid eligibility determination process.

10011 Covered Services

CHOICE funds may only be used to purchase specified services.
(Authority IC 12-10-10, 460 IAC 1-4-11,460 IAC 1.2-5-1(e))

CHOICE funded services are limited to:

(A) Adaptive aids and devices.

(B) Adult day services.

(C) Attendant care.

(D) Case management services.

(E) Environmental modifications.

(F) Family caregiver support.

(G) Home health services.

(H) Home delivered meals.

(I) Homemaker.

(J) Home repair and maintenance services.

(K) Information and assistance.

(L) Legal assistance services.

(M) Nutrition education / counseling.

(N) Outreach services.

(O) Respite care.

(P) Therapy services.

(Q) Transportation.

(R) Self-directed attendant care services provided by a registered personal services attendant under the applicable statute to persons in need of self-directed in-home care.

(S) Other services necessary to prevent institutionalization of eligible individuals when feasible as authorized on the plan of care.

10012 CHOICE and Hospice Services

CHOICE participants may receive Medicare and/or Medicaid hospice services and CHOICE funded services and supports, but these services must be coordinated to ensure non-duplication of services and payment.
(Authority, IC 12-10-10, 460 IAC 1-4-11)

(1) The case manager, upon learning of an individual's election (or plan to elect) the hospice benefit under Medicare and/or Medicaid, shall contact the individual and the hospice case manager to review the need to coordinate services.

(A) Hospice services include a range of services designed to address the needs of individuals with a terminal illness. Services include: nursing services; medical social services; physician services; counseling services, including dietary and bereavement counseling; short-term inpatient care, including respite care; medical appliances and drugs; home health aide and homemaker services; physical therapy; occupational therapy; and speech-language pathology services. In addition, Medicare covers any other service that is specified in the hospice plan of care, and for which payment may otherwise be made under Medicare.

The most common hospice services in danger of duplication with CHOICE-funded services are home health aide and homemaker services. Hospice, except when provided as an inpatient service, provides intermittent services that do not include sitter or companion services. Services are not designed, for example, to provide care, to enable a caregiver to go to work.

(B) The case manager must review the hospice plan of care and reduce CHOICE services that are duplicative of services contained in the hospice plan of care and terminate CHOICE-funded respite services, for as long as the individual remains enrolled in hospice. A CHOICE recipient **may not** refuse hospice

services in order to continue to receive a comparable service funded by CHOICE.

(C) When an individual elects hospice services, they may not receive paid respite services funded by CHOICE but instead must utilize hospice respite services, if not a duplicate service.

(D) The CHOICE case manager and hospice case manager should explain to the individual the services covered through both programs and the reductions that are being made and the reasons for the reductions (e.g. to ensure non-duplication of services and payment).

10013 CHOICE and Self-Directed Attendant Care

CHOICE participants may choose to self-direct personal attendant services as specified in this section.
(Authority, IC 12-10-10, IC 12-10-17, 460 IAC 1-4-11)

(1) CHOICE participants may choose to self-direct personal attendant services if they are an "individual in need of self-directed in-home care".

(A) An ”individual in need of self-directed in-home care” means a disabled individual, or person responsible for making health related decisions for the disabled individual, who:

i is approved to receive Medicaid HCBS waiver services or is a CHOICE participant;

ii is in need of attendant care services because of impairment;

iii requires assistance to complete functions of daily living, self-care, and mobility, including those functions included in attendant care services;

iv chooses to self-direct a paid personal services attendant to perform attendant care services; and

v assumes the responsibility to initiate self-directed in-home care and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss a personal services attendant.

(B) "Attendant care services" means those basic and ancillary services, which the individual chooses to direct and supervise a personal services attendant to perform, that enable an individual in need of self-directed in-home care to live in the individual's home and community rather than in an institution and to carry out functions of daily living, self-care, and mobility.

(C) "Basic services" means a function that could be performed by the individual in need of self-directed in-home care if the individual were not physically disabled. The term includes the following:

i Assistance in getting in and out of beds, wheelchairs, and motor vehicles.

ii Assistance with routine bodily functions.

iii Health related services.

iv Bathing and personal hygiene.

v Dressing and grooming.

vi Feeding, including preparation and cleanup.

(D) “Health related services" means those medical activities that, in the written opinion of the attending physician submitted to the case manager of the individual in need of self-directed in-home care, could be performed by the individual if the individual were physically capable, and if the medical activities can be safely performed in the home, and:

i are performed by a person who has been trained or instructed on the performance of the medical activities by an individual in need of self-directed in-home care who is, in the written opinion of the attending physician submitted to the case manager of the individual in need of self-directed in-home care, capable of training or instructing the person who will perform the medical activities; or

ii are performed by a person who has received training or instruction from a licensed health professional, within the professional's scope of practice, in how to properly perform the medical activity for the individual in need of self-directed in-home care.

(E) "Licensed health professional" means the following:

- A registered nurse.
- A licensed practical nurse.
- A physician with an unlimited license to practice medicine or osteopathic medicine.
- A licensed dentist.
- A licensed chiropractor.
- A licensed optometrist.
- A licensed pharmacist.
- A licensed physical therapist.
- A certified occupational therapist.
- A certified psychologist.
- A licensed podiatrist.
- A licensed speech-language pathologist or audiologist.

(F) "Ancillary services" means services ancillary to the basic services provided to an individual in need of self-directed in-home care who needs at least one (1) of the basic services (as defined in section 4 of this chapter). The term includes the following:

i Homemaker type services, including shopping, laundry, cleaning, and seasonal chores.

ii Companion type services, including transportation, letter writing, mail reading, and escort services.

iii Assistance with cognitive tasks, including managing finances, planning activities, and making decisions.

(2) Individuals self directing their own care must have the approval of their attending physician.

(A) The case manager must maintain an attending physician's written opinion in the individual's case file regarding the opinion of the individual's attending physician that the health related services could be performed by the individual if the individual were physically capable, and if the medical activities can be safely performed in the home, and:

i are performed by a person who has been trained or instructed on the performance of the medical activities by an individual in need of self-directed in-home care and, in the written opinion of the attending physician, the individual in need of self-directed in-home care is capable of training or instructing the person who will perform the medical activities; or

ii are performed by a person who has received training or instruction from a licensed health professional, within the professional's scope of practice, in how to properly perform the medical activity for the individual in need of self-directed in-home care.

(3) Responsibilities for self-directed care:

(A) The individual in need of self-directed in-home care is responsible for recruiting, hiring, training, paying, certifying any employment related documents, dismissing, and supervising in the individual's home during service hours a personal services attendant who provides attendant care services for the individual.

(B) If an individual in need of self-directed in-home care is less than twenty-one (21) years of age or unable to direct in-home care because of a brain injury or mental deficiency, the individual's parent, spouse, legal guardian, or a person possessing a valid power of attorney may make employment, care, and training decisions and certify any employment related documents on behalf of the individual.

(C) An individual in need of self-directed in-home care or an individual under subsection (B) and the individual's case manager shall develop an authorized plan of care. The authorized plan of care must include a list of weekly services or tasks that must be performed to comply with the authorized plan of care.

(4) Parents, spouses, or other adults legally responsible for the individual may not provide attendant care services for compensation under this legislation.

(5) Providers of CHOICE-funded self-directed care must comply with the requirements.

(6) Upon request, the FSSA DA will provide to an individual in need of self-directed in-home care the following:

(A) A list of personal services attendants who are registered with the division and available within the requested geographic area will be provided without charge,

(B) A copy of the information of a specified personal services attendant who is registered with the FSSA DA. The division may charge a fee for shipping, handling, and copying expenses.

(7) The individual in need of self-directed in-home care and the personal services attendant must each sign a contract, in a form approved by the FSSA DA, that includes, at a minimum, the following provisions:

(A) The responsibilities of the personal services attendant.

(B) The frequency the personal services attendant will provide attendant care services.

(C) The duration of the contract.

(D) The hourly wage of the personal services attendant. The wage may not be less than the federal minimum wage or more than the rate that the recipient is eligible to receive under a Medicaid home and community based services waiver or the community and home options to institutional care for the elderly and disabled program for attendant care services.

(E) Reasons and notice agreements for early termination of the contract.

(8) A personal services attendant who is hired by the individual in need of self-directed in-home care is an employee of the individual in need of self-directed in-home care. The division is not liable for any actions of a personal services attendant or an individual in need of self-directed in-home care. A personal services attendant and an individual in need of self-directed in-home care are each liable for any negligent or wrongful act or omission in which the person personally participates.

10014 CHOICE Fund Prohibited Uses

CHOICE funds may not be used for some purposes or activities.
(Authority IC 12-10-10, 460 IAC 1-4-7, 460 IAC 1-4-11)

Choice funds **may not** be used to:

(1) purchase services or supports available from another funding source, including but not limited to: Medicare, private long-term care insurance, Vocational Rehabilitation, Medicaid state plan and Medicaid HCBS waivers.

(2) purchase real estate.

(3) provide care or services to an individual residing in an institution. However, funds may be used for assessment and plan of care development for current residents in institutions who could return to their homes if determined to be eligible for the CHOICE program. Assisted living facilities are not considered institutional settings.

(4) home modification will be acceptable for an individual residing in an institution if used to transition an individual back into the home.

10015 Unusual Occurrences/Incident Reporting

Any person with direct monitoring responsibilities shall report all incidents that meet the definition of a reportable unusual occurrence in accordance with the requirements of Indiana FSSA DA Incident Reporting Policy.
(Authority IC 12-10-10, 460 IAC 1.2-8-2, 460 IAC 1-4-11)

All incidents classified as reportable unusual occurrences shall be reported to the DA, and to APS or CPS when applicable, and in accordance with the FSSA DA Incident Reporting Policy. Refer to the Indiana FSSA DA Incident Reporting Policy for definitions, policy and procedure.

10016 CHOICE Applicant and Participant Appeals

CHOICE applicants have a right to appeal AAA decisions regarding eligibility or services to be provided. (Authority IC 12-10-10, 460 IAC 1-4-3, 460 IAC 1-4-11) Refer to Section 3007 of the Division of Aging Operations Manual.

10017 CHOICE Plan

A CHOICE Plan must be submitted each year with the Area Plan or Area Plan Update. Procedures for making CHOICE program information available to applicants, participants and the public.

CHOICE Plan Contents and Format:

Section 1 – Intake and Referral Process

- Description of the referral and intake process, including eligibility determination protocols and method of eligibility notification.

Section 2 – Assessment Process

- Description of the assessment process, format, and procedures used by AAA case managers including methodology for ensuring completion of ninety-day face-to-face assessments of CHOICE participants.

Section 3 – Nursing Home Outreach

- Describe the outreach and follow up methods for offering assessments to current nursing home residents who apply for CHOICE.

Section 4 – Hiring Practices

- Describe the methods of recruitment, screening, and hiring of staff.

Section 5 – Care Plan Development Process

- Description of the procedures used to develop the plan of care including a timeline for the development process from start to implementation of services. Also a description of the role the individual and/or their family play in the development of their care plan.

Section 6 – Area and Community Support Services

- A list of all available long-term support services, both public and private, within the area.

Section 7 – Case Management and Service Coordination

- Policies and procedures for the case management and service coordination.

Section 8 – Coordinating CHOICE with Other Funding Sources

- Policies and procedures for coordinating CHOICE with Medicaid state plan services, HCBS waiver services and other funding sources for in-home and community-based services. Describe the methodology for determining priority funding, last resort funding, and preventing duplication of services among funding sources.

Section 9 – QA/QI Plan

- Description of quality assurance (QA) and quality improvement (QI) plan for CHOICE services consistent with FSSA DA QA/QI requirements for HCBS.

Section 10 – Plans of Care Evaluation and Monitoring

- Description of internal methods of evaluating plans of care to ensure participants are receiving quality services and direction. Describe how plans of care are selected for review, who conducts the monitoring, what criteria is used to evaluate the appropriateness of service and stewardship of funding, and the frequency of monitoring. Include policies and procedures for conducting QIPs internally and in collaboration with FSSA DA or its contractor.

Section 11 – Follow up and Incident Reporting

- Description of processes and procedures for participant follow up and incident reporting.

Section 12 – Mortality Reviews

- Policies and procedures for responding to mortality reviews conducted by FSSA in accordance with the FSSA DA Mortality Review Policy for HCBS.

Section 13 – Cost Sharing

- Description of CHOICE cost sharing plan procedures, including cost share collection methods.

Section 14 – Complain and Appeal Procedures

- Description of complaint and appeal procedures, which include the process for notifying applicants or participants of the right to an administrative hearing, which incorporates the FSSA DA Complaint Policy for HCBS.

Section 15 – Waiting List

- Description of policies and procedures for operating, maintaining and clearing the AAA waiting list for CHOICE services in accordance with the requirements contained in these CHOICE Guidelines.

Section 16 – Budget

- Budget Narrative and breakdown of spending in accordance with the contract between AAA and FSSA DA on the following categories:

1. A Breakdown of Proposed Spending on Consumer Services
2. Assessments
3. Care Plan Development
4. Reassessments
5. AAA Administration
6. Any Other Appropriate Costs

Section 17 – Provider Selection

- Description of processes and procedures for selecting service providers. Including methods for ensuring a variety of CHOICE providers for participants to choose from.

10018 AAA CHOICE Reporting

Before October 1st of each year, the AAA is required to report both programmatic and fiscal information from the previous state fiscal year, July 1 to June 30, to the FSSA DA. FSSA DA uses the data to prepare a report for review by CHOICE Board and the Indiana General Assembly (Authority IC 12-10-10, 460 IAC 1-4-11).

(1) Each AAA shall provide an annual report that details:

(A) The amount of CHOICE funds spent;

(B) Administrative expenses for CHOICE;

(C) The use of CHOICE funds in supplementing the funding of services provided to individuals through other programs;

(D) The waiting list for CHOICE including numbers of persons on the waiting list, movement off the waiting list and actions taken to clear the waiting list;

(E) The number, capacity and types of participating CHOICE providers;

(F) An examination of CHOICE participants':

i Demographic characteristics;

ii Impairment and medical characteristics;

iii Reportable unusual occurrences/incidents;

iv Grievances and Appeals;

v Length of time receiving CHOICE services in 30 day increments; and

vi The number of CHOICE participants leaving the CHOICE program by month, their reason for leaving and final disposition.

(G) CHOICE participant outcomes;

(H) A determination of the estimated number of CHOICE applicants who have:
i one (1) assessed activity of daily living that cannot be performed;
ii two (2) assessed activities of daily living that cannot be performed; and
iii three (3) or more assessed activities of daily living that cannot be performed;

(I) Children's CHOICE and CHOICE/TANF expenditures (see Section 100004); and

(J) The AAA will complete the cost share report generated from INsite and send to FSSA DA on a quarterly basis.

(K) Choice data for each month must be entered into INsite by the 10th of the following month.

10019 Case Management

Case Manager Qualifications
(Authority IC 12-10-10, IC 12-10-10-1, 460 IAC 1.2, 460 IAC 1-4-3, 460 IAC 1-4-11)

Case managers must meet specific requirements regarding qualifications and certification in order to be eligible to perform CHOICE program-related duties. Case managers must be employees of the AAA formally assigned to carry out the AAA's responsibility for case management.

Case managers and applicants must meet the following qualifications:

(A) Possess a degree or licensing as described below:

i. Bachelor's Degree in social work, psychology, gerontology, sociology, counseling, nursing; or

ii. A license as a Registered Nurse with one year of experience in human services; or

iii. A Bachelor's Degree in any other field with a minimum of two years, full-time direct service experience with the elderly or persons. This experience must include assessment, plan of care development, implementation, and monitoring.; or

iv. A Master's Degree in a related field may substitute for the required experience.

(B) A current limited criminal history obtained from the Indiana State Police Central Repository, as prescribed in 460 IAC 1.2-15-2(b)(2). Applicants with any criminal convictions including, but not limited to, the following may not be certified:

i. A sex crime (IC 35-42-4).

ii. Exploitation of an endangered adult (IC 35-46-1-12).

iii. Abuse or neglect of a child (IC 35-42-2-1).

iv. Failure to report battery, neglect, or exploitation of an endangered adult or dependent (IC 35-46-1-13).

v. Theft (IC 35-43-4), except as provided in IC 16-27-2-5(a)(5).

vi. Murder (IC 35-42-1-1).

vii. Voluntary manslaughter (IC 35-42-1-3).

viii. Involuntary manslaughter (IC 35-42-1-4).

ix. Battery (IC 35-42-2).

(C) Applicants have the right to appeal adverse determinations.

Criminal or Juvenile History Appeals: The subject of a record may initiate a challenge as to the accuracy/completeness of any entry on his/her record. For Indiana entries on the report, challenges should be directed to: Indiana State Police, Records Division, Indiana Government Center North, Room N302, 100 North Senate Ave., Indianapolis, IN 46204. For federal entries on the report, challenges should be directed to: FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. All Other Criminal/Civil History Appeals: The local DCS office will provide contact information for the appropriate agency.

Case Manager Certification

The AAA makes decisions regarding certification based upon the submitted documentation. The decision regarding certification is sent to the candidate with a copy sent to the FSSA DA. Each AAA must certify case managers according to the following criteria:

(A) The applicant's compliance with and completion of all applicable provider requirements.

(B) The applicant's demonstrated qualifications and abilities to determine the needs of community alternatives to institutional placement available. Case managers must have knowledge of the disabilities/conditions of the persons served by CHOICE.

(C) Be at least eighteen (18) years of age, competent to provide services, and demonstrate the ability to communicate.

(D) Provide a copy of a current negative TB test or negative chest x-ray annually.

i Possess a current, valid state-issued driver's license if the employee will be transporting an individual and provide proof of current insurance on the vehicle used to transport

(1) CHOICE case managers must complete training specific to the CHOICE program before performing CHOICE program-related duties.

(A) All case managers must attend the FSSA DA "Case Management Orientation" within the first six months of employment with an AAA and obtain at least 20 hours of additional training each year.

(B) Case Manager Orientation Training is exclusive to new case managers. Case managers who have already attended Case Manager Orientation Training shall not be invited to attend a second time.

Case Manager Non-Compliance

CHOICE case managers who do not comply with CHOICE program requirements will be subject to corrective action up to and including decertification (Authority IC 12-10-10, 460 IAC 1-4-11)

(1) A CHOICE case manager may be subject to corrective action and/or decertified for failure to comply with CHOICE requirements, including provider requirements specified in this Chapter.

(A) Corrective action shall be initiated at the option of the AAA and may include, but is not limited to:

i Removal from an active caseload for retraining;

ii Attendance at prescribed training sessions;

iii One-to-one follow along by a case manager assigned by the AAA; and/or

iv Suspension for a prescribed period of time followed by any of (i) through (iii) above.

A CHOICE case manager will be decertified (de-activated) as of the case manager's last date of employment. A case manager shall NOT be decertified for a temporary absence, such as for maternity, medical, or family leave.

Case Management Responsibilities and Standards

(Authority IC 12-10-10, 460 IAC 1.2-17-7, 460 IAC 1.2–17-2460 IAC 1-4-11, 460 IAC 1-4-2, 460 IAC 1.2-8-1, 460 IAC 1.2-9-2)

Each AAA is responsible for performance and oversight of "case management" functions for CHOICE and the standards by which case managers operate, which include:

(A) Assessing the individual to determine functional impairment level and corresponding need for services;

(B) Identifying all sources of funding, services and supports other than CHOICE. CHOICE is last resort funding.

(C) Developing a plan of care that addresses the individual's needs; Case managers will ensure that "person centered planning" is utilized in the development of the individual's CHOICE plan of care and while they receive services.

(D) Reviewing and explaining to the individual/guardian the services that will be provided and obtaining all required signatures on the plan of care before submitting it to the Area Agency on Aging. Any plan of care requiring State approval will not be implemented prior to obtaining State approval.

(E) Supervising the implementation of services for the individual; Case managers shall ensure a maximum response time between implementation of the initial plan of care and the first monitoring contact will be no more than thirty (30) calendar days. Case managers will complete face-to-face contact with each individual a minimum of every ninety (90) days to assess the quality and effectiveness of the plan of care.

(F) Advocating on behalf of the individual's interests; Case managers will communicate the individual's needs, strengths and preferences to appropriate persons including CHOICE providers and other persons of the individual's choosing. Case managers will regularly inform individual's of their right to refuse treatment or seek a change to their plan of care.

(G) Monitoring the quality of community and home care services provided to an eligible individual and ensuring that plan of care objectives are being met. Case managers will document within seven (7) days, in the chronological narrative, each contact with the individual and with the providers.

(H) Determining the cost effectiveness of using in-home and community services as alternatives to traditional care or services. Case managers will monitor the services being provided to ensure good stewardship of the funding.

(I) Reassessing the plan of care to determine the continuing need or termination of services. At least two of these face-to-face contacts per year will be in the home setting. Case managers will complete annual assessments and care plan updates with the individual in a timely manner to avoid gaps in service authorization.

(J) Providing each individual/guardian with clear and easy to understand instructions for contacting the case manager. The case manager will also provide additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours.

(K) Providing information and referral services to individuals in need of community and home care services; Case managers will provide, at a minimum but not limited to, a state information guide as provided by the Division of Aging to individuals on how to choose a provider and will assist the individual to evaluate potential service providers.

(L) Performing record keeping and data collection activities, including the import and export of case records at a minimum of every seven (7) calendar days; Case managers will keep all files in a standardized format and sequence and provide the State ready access to all case manager documentation shall a request be made.

(M) Providing community education regarding the case management system.

(N) Establishing relationships with existing service providers and collaborating with the other service providers to coordinate services consistent with the participant's plan of care.

(O) Providing continuous supervision of case managers. Ensuring compliance with all DA issued manuals, as well as all federal, state, and local law, and all FSSA policy, rules, regulations and guidelines.

(P) Ensuring the case management system has access to administrative and support services.

(Q) Facilitating and monitoring the formal and informal supports that are developed to maintain the individual's health and welfare in the community.

(R) Ensuring confidentiality of individual information. Case managers will maintain privacy and confidentiality of all individual records and follow all applicable guidelines set forth in this section regarding record access.

(S) Performing an assessment and planning for discharge from an institutional setting.

(T) Maintaining the highest professional and ethical standards.

(U) Ensuring individuals have a free choice of service provider, and of case manager, and shall have the right to change any provider or case manager. Case managers will provide to individuals a list of potential providers the services offered.

(V) Ensuring unusual occurrences/incidents made known to the case manager are reported and addressed in accordance with the FSSA DA Incident Reporting

Policy for HCBS and in accordance with Indiana mandatory reporting requirements when applicable.

(W) Conducting follow-up evaluations for individuals terminated from CHOICE.

10020 Plan of Care

The case manager shall initiate a plan of care and work with the individual, to develop the plan of care with respect to the individual's unique needs and wishes.

(Authority IC 12-10-10, 460 IAC 1-4-3, 4, 5, 6, 460 IAC 1.2-19-1, 460 IAC 1-4-11)

The case manager shall initiate a CHOICE plan of care for each person eligible for CHOICE regardless of the applicant's income and assets, except when:

(A) The applicant or his or her CHOICE representative does not want to proceed with the development of a plan of care;

(B) The applicant or his or her CHOICE representative refuses to release the information that is necessary to develop a plan of care; and/or

(C) The AAA does not have the resources, within the available funds, to develop and carry out a plan of care.

Preliminary Information Gathering

The case manager shall have available or gather the following information concerning the participant prior to initiation of the plan of care:

(1) The needs and wants of a participant including their health, welfare, and wishes for self-directed care.

(2) All services available regardless of funding source or community resource provider.

(3) A list of service the participant is eligible for and the funding available for each of those services.

Plan of Care Development

The plan of care shall be developed in collaboration with the individual and shall include a formal description of goals, objectives, and strategies designed to enhance independence.

- CHOICE plans of care shall be developed within 14 calendar days of the date of the assessment, except when the AAA does not have the resources, within the available funds, to develop and carry out a plan of care. When funds are not available, development of a plan of care shall be deferred until such time as funds become available. When funding becomes available, the plan of care shall be developed within 14 days of availability of these funds. At that time the previous assessment shall be reviewed and revised, if needed, prior to completion of the plan of care.
- The long-term care services eligibility screen developed by the FSSA DA shall be used by the AAA to assess the applicant's risk of losing his or her independence and to assist in the development of a plan of care, if appropriate.

- The participant has the right to be involved in the formulation of the plan of care and shall be involved at every stage of decision making regardless of their care or living situation. The applicant, or their CHOICE representative, may decide whether family or others may participate in the development of the plan of care and updates that may follow.
- During the development of the plan of care, necessary communication assistance shall be provided at no cost to the participant.
- Each plan of care shall include services that may be funded by CHOICE when necessary to meet an individual's assessed needs and subject to specific CHOICE fund limitations.
- Each plan of care must be developed in accordance with limitations specific to CHOICE funds.
    - i CHOICE funds may be used for services authorized under the CHOICE program.
    - ii Some services that may be funded with CHOICE funds require additional documentation to establish necessity and appropriateness of the service.
    - iii CHOICE funds are the funding of last resort.
    - iv CHOICE funds <u>may not be authorized</u> for any individual who has not applied for, or received, a Medicaid eligibility determination within the last ninety days.
    - v There is an individual cap on CHOICE funds that must be applied during plan of care development.

    (D) Each plan of care shall address:

    - i The individual's personal goals in key life areas including home life, health care, community participation and self-direction;
    - ii The individual's daily living needs and preventative health care needs as well as any other identified needs;
    - iii The services needed to maintain independence.
    - iv The cost of the services still needed.
    - v The sources of all services and support available to meet the individual's needs whether paid or unpaid, including the payment sources of those services and the no-cost or voluntary services that can be provided to meet the individual's needs.
    - vi The requested and authorized CHOICE service(s) when necessary to meet an individual's assessed needs and subject to specific CHOICE fund limitations. The plan of care shall specify for each authorized CHOICE service;
        - *(a)* The frequency of the service(s);
        - *(b)* The duration of the service(s);
        - *(c)* The provider of the service(s);
        - *(d)* Any special instructions specific to the service(s); and
        - *(e)* Provisions for back-up services and emergencies.

(E) The plan of care must be signed by the applicant or by his or her CHOICE representative.

i If the case manager has reason to believe that an individual lacks the capacity to make a knowing and informed decision regarding his or her own care, the case manager shall consult with the individual's physician. The individual's physician shall make a determination regarding the individual's capacity to make a knowing and informed decision. If the physician determines that the individual lacks the capacity to make a knowing and informed decision regarding his or her own care, the plan of care and any revisions must be approved and signed by the individual's CHOICE representative.

ii If the individual is physically unable to sign the application or plan of care, but has the capacity to make a knowing and informed decision regarding his or her own care, the individual may indicate his or her assent and authorize another to sign.

iii There shall be documentation in the case file that the individual (and/or representative, if any) has reviewed and approved the plan of care.

(F) Notwithstanding the fact that an individual needs a CHOICE representative, the case manager shall work and consult with the individual who will be receiving the services and shall take his or her preferences into consideration when developing a plan of care, to the extent that the individual's health or safety is not threatened. The case manager shall ensure the individual, individual's legal representative if applicable, and providers of services regardless of whether the services are CHOICE services or received from another sources, are provided with copies of relevant documentation.

i Copies of relevant documentation shall include information on individual rights, an individual's plan of care, how to file complaints with FSSA DA, and requesting appeals concerning issues and disputes relating to the services provided to the individual.

ii A copy of the plan of care shall be given to the applicant/participant upon completion of the plan of care, upon revision to the plan of care and at any other time upon request.

10021 Confidentiality

(Authority P.L. 104-91)

The AAA shall maintain individual case records for each individual who applies for or receives services. These records shall be maintained for a minimum of seven years after the individual's termination from the program or other final action.

The AAA shall maintain the confidentiality of CHOICE files and records at all times. Such files and records shall not be disclosed except:

(1) to the individual or their CHOICE representative;

(2) to a person representing the individual in an appeal from a CHOICE decision;

(3) to the division or other state agencies for purposes of securing in-home and community services;

(4) to an adult or child protective services investigator under IC 12-10-3 and IC 31-6-11-3;

(5) under court order; or

(6) as authorized by the individual or their CHOICE representative.

The AAA shall use CHOICE records for purposes of the CHOICE program and for the coordination of other related services only.

10022 Provider Requirements – General

CHOICE funded services may only be provided by authorized service providers. (Authority, IC 12-10-10, 460 IAC 1.2, 460 IAC 1-4-3, 460 IAC 1-4-11)

(1) Each AAA shall arrange for the provision of individually needed CHOICE services through local provider agencies or individuals who are approved to provide CHOICE-funded services.

(2) Providers of self-directed attendant care services funded under CHOICE are exempt from the following provisions, but are required to comply with Section 10013, Self-Directed Attendant Care.

(3) In order to become an approved CHOICE provider of HCBS, an entity shall do the following:

(A) Meet the current minimum service provider requirements as specified in this Chapter or show proof of licensure or certification from the state of Indiana, if a license is required.

i Providers that are licensed and regulated by the Indiana state department of health (ISDH) shall be deemed approved for those licensed services.

ii For services not licensed by the ISDH, the provider must meet all other requirements to provide the specified service(s).

(B) Be certified and/or enrolled to provide services for **both** CHOICE and Medicaid HCBS waiver program consumers.

(C) Certify that, if approved, the entity will provide HCBS using only persons who meet the qualifications specified in this Chapter.

(D) Retain, and have readily available, a copy of the most current executed signed provider agreement or contract as applicable.

(E) Assure and document compliance with the executed provider agreement or contract and the requirements of this Chapter.

(F) Comply with the following:

i Applicable federal, state, county, or municipal regulations that govern the operation of the agency.

ii FSSA laws, rules, and policies.

(G) Provide proof of the following:

i That insurance is in force as prescribed in 460 IAC 1.2-12-1(4).

ii That any employee, agent, or staff of the provider agency meets all standards and requirements for the specific services the person will be providing.

iii That licensed health professionals are checked for findings through the Indiana professional licensing agency.

(H) Obtain a current limited criminal history obtained from the Indiana state police central repository, as prescribed in 460 IAC 1.2-15-2(b)(2), for each employee or agent involved in the direct management, administration, or provision of services before providing direct care to individuals receiving services.

i Providers may not be, or may not employ or contract with, a person convicted of crimes including, but not limited to, the following:

(a) A sex crime (IC 35-42-4).

(b) Exploitation of an endangered adult (IC 35-46-1-12).

(c) Abuse or neglect of a child (IC 35-42-2-1).

(d) Failure to report battery, neglect, or exploitation of an endangered adult or dependent (IC 35-46-1-13).

(e) Theft (IC 35-43-4), except as provided in IC 16-27-2-5(a)(5).

(f) Murder (IC 35-42-1-1).

(g) Voluntary manslaughter (IC 35-42-1-3).

(h) Involuntary manslaughter (IC 35-42-1-4).

(i) Battery (IC 35-42-2).

ii Criminal or Juvenile History Appeals: The subject of a record may initiate a challenge as to the accuracy/completeness of any entry on his/her record. For Indiana entries on the report, challenges should be directed to: Indiana State Police, Records Division, Indiana Government Center North, Room N302, 100 North Senate Ave., Indianapolis, IN 46204. For federal entries on the report, challenges should be directed to: FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. All Other Criminal/Civil History Appeals: The local DCS office will provide contact information for the appropriate agency.

(I) Obtain and submit a current document from the nurse aide registry of the Indiana State Department of Health verifying that each unlicensed employee or

agent involved in the direct provision of services has no finding entered into the registry, if applicable, before providing direct care to individuals receiving services.

(J) Ensure staff providing direct care for CHOICE participants:

i Are at least eighteen (18) years of age.

ii Are competent to provide services according to the individual's plan of care.

iii Demonstrate the ability to effectively communicate.

iv Submit a copy of a current negative TB test or negative chest x-ray that is completed annually.

v Possess a current, valid state-issued driver's license if the employee will be transporting an individual. Provide proof of current insurance on the vehicle used to transport an individual that meets current Indiana requirements.

(K) The provider shall maintain documentation that the provider meets the requirements and maintains the minimum standards set out in this Chapter for providing CHOICE-funded services.

10023 Provider Requirements – Organizational Chart Guideline.

CHOICE providers shall maintain and make available an organizational chart.
(Authority IC 12-10-10, 460 IAC 1.2-9-1,460 IAC 1-4-11)

10024 Provider Requirements – Personnel Records

CHOICE providers shall maintain in the provider's office, files for each employee or agent of the provider.
(Authority, IC 12-10-10, 460 IAC 1.2-14-1, 460 IAC 1-4-11)

(1) The files for each employee or agent who provides direct care shall contain the following:

(A) An annual negative tuberculin skin test or chest x-ray before providing services, updated in accordance with recommendations of the Centers for Disease Control.

(B) Copies of the current, valid state-issued driver's license and automobile insurance information, updated when the insurance is paid, if the employee or agent will be transporting an individual.

(C) Limited criminal history information that meets the requirements of 460 IAC 1.2-6-2(3).

(D) Current CPR certification updated in accordance with one (1) of the following:

i The American Heart Association.

ii The American Red Cross.

iii Another entity approved by FSSA DA.

(E) Verification of each training session attended by the employee or agent, including substantiation of the following:

i The content.

ii The length of the training session.

iii Identification of the trainers.

iv Dated signatures of the trainers and the employee.

(2) The files for each employee or agent who does not provide direct care shall contain the following:

(A) Limited criminal history information that meets the requirements of 460 IAC 1.2-6-2(3).

(B) Professional licensure, certification, or registration, including renewals, as applicable.

(C) Verification of each training session attended by the employee or agent, including substantiation of the following:

i The content.

ii The length of the training session.

iii Identification of the trainers.

iv Dated signatures of the trainers and the employee.

10025 Provider Requirements – Personnel Policies and Manuals

CHOICE providers, who use employees or agents to provide services shall adopt, maintain and ensure compliance with personnel policies and manuals.
(Authority IC 12-10-10, 460 IAC 1.2-15, 460 IAC 1-4-11)

(1) A provider or its agent shall adopt, maintain, and follow a written personnel policy. The written personnel policy shall:

(A) Be reviewed at least annually and updated as needed.

(B) Be provided to each employee or agent.

(C) Include, but is not limited to, the following:

i A procedure for conducting reference, employment, and criminal background checks on each prospective employee or agent.

ii A prohibition against employing or contracting with a person convicted of crimes including, but not limited to, the following:

(a) A sex crime (IC 35-42-4).

(b) Exploitation of an endangered adult (IC 35-46-1-12).

(c) Abuse or neglect of a child (IC 35-42-2-1).

(d) Failure to report battery, neglect, or exploitation of an endangered adult or dependent (IC 35-46-1-13).

(e) Theft (IC 35-43-4), except as provided in IC 16-27-2-5(a)(5).

(f) Murder (IC 35-42-1-1).

(g) Voluntary manslaughter (IC 35-42-1-3).

(h) Involuntary manslaughter (IC 35-42-1-4).

(i) Battery (IC 35-42-2).

(D) A process for evaluating the job performance of each employee or agent at the end of the training period and annually thereafter, including a process for feedback from individuals receiving services from the employee or agent.

(E) Disciplinary procedures.

(F) A description of grounds for disciplinary action against or dismissal of an employee or agent.

(G) A clear description of an employee's rights and responsibilities, including the responsibilities of administrators and supervisors.

(H) A procedure to ensure compliance with HIPAA regulations.

(2) A provider or its agent shall adopt and maintain a job description for each position, including the following:

(A) Minimum qualifications for the position.

(B) Major duties required of the position.

(C) The written personnel policy required by subsection (1).

(3) A provider or its agent shall ensure compliance with and compile written policies and procedures specified in this section into a written operations manual.

(A) The operations manual shall be regularly updated and revised not less often than annually.

(B) Upon the request of FSSA DA or its designee, the provider shall do either of the following:

i Supply a copy of the operations manual to FSSA DA or its designee, or another state agency at no cost. FSSA DA will maintain the confidentiality of proprietary information, as deemed appropriate.

ii Make the operations manual available to FSSA DA or its designee, or another state agency for inspection at the offices of the provider.

10026 Provider Requirements – Maintenance of Records of Services Provided

A CHOICE provider or its agents shall maintain, in the provider's office, documentation of all services provided to an individual.
(Authority, IC 12-10-10, 460 IAC 1.2-16, 460 IAC 1-4-11)

(1) A CHOICE provider or its agents shall:

(A) Maintain, in the provider's office, documentation of all services provided to an individual.

(B) Analyze and maintain the documentation required by the following:

i CHOICE standards applicable to the services the provider is providing to an individual.

ii The professional standards applicable to the provider's profession.

iii The individual's plan of care.

(2) Documentation related to an individual and required by this article shall be maintained by the provider per HIPAA guidelines following the end of service provision by the provider or its agent to the individual or as specified in law or rule.

10027 Provider Requirements – Data Collection Standards

CHOICE providers shall comply with data collection and reporting standards.
(Authority IC 12-10-10, 460 IAC 1.2-9-4, 460 IAC 1-4-11)

A provider or its agent shall utilize the INsite state-approved data collection system.

10028 Provider Requirements – Billing Standards

CHOICE providers shall comply billing standards.
(Authority IC 12-10-10, 460 IAC 1.2-9-4, 460 IAC 1-4-11)

10029 Provider Requirements – Disclosure of Financial Information

CHOICE providers shall comply with financial disclosure requirements specified in this Section.
(Authority 460 IAC 1.2-10-1, 460 IAC 1-4-11)

(1) A provider or its agent shall do the following:

(A) Maintain financial records in accordance with generally accepted accounting and bookkeeping practices.

(B) Be audited as follows:

i Under the direction of the provider agreement or contract.

ii According to state board of accounts requirements and procedures for the services contracted. http://www.in.gov/sboa/publications/

(2) A provider will, upon request, provide to the AAA and/or FSSA DA copies of audit findings.

10030 Provider Requirements – Insurance

CHOICE providers shall secure insurance as specified in this Section.
(Authority IC 12-10-10, 460 IAC 1.2-11-1, 460 IAC 1-4-11)

A provider shall secure insurance to cover at least personal injury, loss of life and property damage to an individual caused by fire, accident, or other casualty arising from the provision of services to the individual by the provider.

10031 Provider Requirements – Quality Assurance and Quality Improvement System

CHOICE providers or their agent shall have a written internal quality assurance and quality improvement system in accordance with this Section.
(Authority IC 12-10-10, 460 IAC 1.2-9-5, 460 IAC 1-4-11)

(1) A provider's or its agent's written internal quality assurance and quality improvement system shall be:

(A) Focused on the individual.

(B) Appropriate for the services being provided.

(C) Ongoing and updated at least annually.

(2) The system described in subsection (1) shall include at least the following elements:

(A) An annual survey of individual satisfaction, in accordance with contract guidelines.

(B) Records of findings for annual individual satisfaction surveys.

(C) Documentation of efforts to improve service delivery in response to the surveys of individual satisfaction.

(D) An annual assessment of the appropriateness and effectiveness of each service provided to an individual.

(E) A written process for the following, if applicable:

i Analyzing data concerning the following:

(a) Reportable incidents. Reportable incidents are those incidents specified in the Indiana FSSA DA Incident Reporting Policy.

(b) Services provided.

ii Developing and reviewing recommendations to reduce the risk of future incidents.

10032 Transfer of Individual's Records Upon Change of Provider

CHOICE funded services may only be provided by authorized service providers.
(Authority, IC 12-10-10, 460 IAC 1.2-8-3, 460 IAC 1-4-11)

If an individual changes providers for a home and community-based service, the case manager shall facilitate the transfer of pertinent records related to the individual to the new provider within five (5) calendar days while maintaining compliance with HIPAA regulations.

10033 Provider Requirements – Procedures for Protecting Individuals

CHOICE providers shall develop procedures to protect individuals as specified in this section.
(Authority, IC 12-10-10, 460 IAC 1.2-8-1, 460 IAC 1-4-11)

(1) Each provider of services shall maintain specific written safety and security policies and procedures for an individual.

(2) Each provider of services shall train all employees or agents in implementing written safety and security policies.

(3) Each provider of services shall establish a written procedure providing for when and how to notify law enforcement, APS, or CPS, as deemed appropriate and emergency response agencies in an emergency or crisis.

(4) Each provider of services shall establish a written procedure providing for scheduling and completion of evacuation drills when providing services in locations other than an individual's own home (i.e. residential service providers and adult day services providers.)

(A) Adopting procedures that shall be followed in an emergency or crisis, such as any of the following: a tornado, a fire, inclement weather.

(5) Each provider of services shall establish a written procedure providing for:

- administrative action against;
- investigating an alleged violation by;
- disciplinary action against; and
- dismissal of an employee or agent of the provider;

if the employee or agent is involved in the alleged, suspected, or actual abuse, neglect, exploitation, or mistreatment of an individual or a violation of an individual's rights.

(6) Each provider of services shall establish a written procedure for employees or agents of the provider to report violations of the provider's policies and procedures to the provider.

(7) Each provider of services shall establish a written procedure for the provider or for an employee or agent of the provider, for informing:

- APS or CPS as applicable;
- an individual's legal representative, if applicable;
- the appropriate ombudsman;
- any person designated by the individual; and
- the provider of CMS to the individual;

of a situation involving the alleged, suspected, or proven abuse, neglect, exploitation, or mistreatment of an individual or the violation of an individual's rights.

(8) Each provider will inform individuals of their right to exercise any or all guaranteed rights without:

- restraint;
- interference;
- coercion;
- discrimination; or
- threat of reprisal;

by the provider, employee, or agent.

(9) Each provider of services shall establish and make available to the individual; the written protocol for reporting required reportable unusual occurrences to FSSA DA .

(10) Each provider of services shall establish and make available to the individual receiving services a written protocol informing the individual about the right to file a complaint with FSSA DA and the process of filing a complaint with FSSA DA.

10034 Provider Requirements – Individual's "No-Show" for a Service

CHOICE providers shall report individuals who do not report to a location as scheduled for a service as an unusual occurrence in accordance with the requirements of Division of Aging Incident Reporting Policies and Procedures.
(Authority IC 12-10-10,460 IAC 1.2-8-2, 460 IAC 1-4-11)

10035 Legally Responsible Individuals as CHOICE Providers

CHOICE-funded services may only be provided by legally responsible individuals as specified in this section.
(Authority IC 12-10-10)

(1) An individual who is a legally responsible relative of an individual, including a parent of a minor individual and a spouse, is precluded from providing CHOICE-funded services for that individual for compensation unless the individual has completed the FSSA DA program to train relatives of eligible individuals to provide homemaker and personal care services to those eligible individuals.

10036 Provider Requirements – Coordination of Services and Plan of Care

(Authority IC 12-10-10; 460 IAC 1.2-19-1; 460 IAC 1-4-11)

Procedure.

(1) All entities responsible for providing service to an individual shall do the following:

(A) Coordinate the services provided to an individual.

(B) Share documentation regarding the individual's well-being, as required by the individual's plan of care.

10037 Service Specific Provider Requirements – Adaptive Equipment Providers

CHOICE providers of adaptive equipment shall provide this equipment (see Section 4001 of DA Operations Manual).

- Providers must meet requirements contained in the CHOICE guidelines as applicable to the provider.
- Adaptive equipment may be funded by CHOICE if the individual has no other source of funding adaptive equipment.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10038 Service Specific Provider Requirements – Adult Day Services Providers

CHOICE providers of adult day services shall implement services in accordance with the requirements of Section 4003 of the DA Operations Manual.

- Adult Day Services may only be funded by CHOICE if the individual has no other source of funding.
- Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10039 Service Specific Provider Requirements – Attendant Care

CHOICE providers of attendant care services shall implement services in accordance with the requirements of Section 4007 of the DA Operations Manual.

- Attendant care services may only be funded by CHOICE if the individual has no other source of funding.
- Attendant Care Services are a HCBS Waiver service.
- Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider.
- (Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10040 Service Specific Provider Requirements – Environmental Modifications

CHOICE providers of environmental modifications shall implement services in accordance with the requirements of Section 4018 of the DA Operations Manual.

- Environmental Modification Services may only be funded by CHOICE if the individual has no other source of funding.
- Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider.

- Environmental modifications are a HCBS Waiver service.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

(A) Reimbursement for Environmental Modification Supports has a lifetime cap of $15,000. Service and repair up to $500 per year, outside this cap, is permitted for maintenance and repair of prior modifications. (If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.)

10041 Service Specific Provider Requirements – Family Caregiver Support

Family Caregiver Support Program services may only be funded by CHOICE if the caregiver has no other source of funding.

Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10042 Service Specific Provider Requirements – Home Health Services

CHOICE providers of home delivered meals shall implement services in accordance with the requirements of this Section.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10043 Service Specific Provider Requirements – Home Delivered Meals

CHOICE providers of home delivered meals shall implement services in accordance with the requirements of Section 8006 of the DA Operations Manual.

- Home Delivered Meals may only be funded by CHOICE if the individual has no other source of funding.
- No more than two meals per day will be reimbursed under the CHOICE program.
- Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10044 Service Specific Provider Requirements – Homemaker

CHOICE providers of homemaker services shall implement services in accordance with the requirements of Section 4013 of the DA Operations Manual.

- Homemaker Services may only be funded by CHOICE if the individual has no other source of funding.
- Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider and be an enrolled HCBS waiver homemaker provider.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10045 Service Specific Provider Requirements – Home Repair and Maintenance Services

CHOICE providers of home repair and maintenance services shall meet specified requirements and develop and implement safety and security policies and procedures specified in Section 4014 of the DA Operations Manual

- Home Repair and Maintenance Services may only be funded by CHOICE if the individual has no other source of funding.
- Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider and be an enrolled HCBS waiver Home Repair and Maintenance Services provider.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10046 Service Specific Provider Requirements – Information and Assistance

CHOICE providers of information and assistance services shall meet specified requirements and develop and implement safety and security policies and procedures specified in Section 4016 of the DA Operations Manual.

- Information and Assistance Services may only be funded by CHOICE if the individual has no other source of funding.
- Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10047 Service Specific Provider Requirements – Legal assistance services

CHOICE providers of legal assistance services shall meet specified requirements and develop and implement safety and security policies and procedures specified in Section 4017 of the DA Operations Manual.

- Legal Assistance Services may only be funded by CHOICE if the individual has no other source of funding.
- Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10048 Service Specific Provider Requirements – Nutrition Education

CHOICE providers of nutrition education services shall meet specified requirements and develop and implement safety and security policies and procedures specified in this Section.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10049 Service Specific Provider Requirements – Outreach Services

CHOICE providers of outreach services shall meet specified requirements and develop and implement safety and security policies and procedures specified in Section 4021 of the DA Operations Manual.

- Outreach Services may only be funded by CHOICE if the individual has no other source of funding.
- Providers must meet requirements contained in the CHOICE Guidelines as applicable to the provider.

(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10050 Service Specific Provider Requirements – Personal Emergency Response Systems

Personal Emergency Response Systems providers must meet specified requirements to provide CHOICE-funded services.

(Authority IC 12-10-10; 460 IAC 1.2-18-1; 460 IAC 1-4-11)

Procedure.

Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable *help* button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

(1) Service Requirements/Allowable Activities:

(A) PERS consists of:

i Device Installation service; and

ii Ongoing monthly maintenance of device.

(2) Service authorization requirements:

(A) The case manager authorizes PERS.

(3) Limitations/Exclusions

(A) PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision.

(B) Systems must meet Underwriters Laboratory (UL) and FCC regulations prior to installation.

(C) All devices must meet applicable state and local requirements and regulations for licensure and/or certification for the type of system for which the contractor is providing.

(4) PERS providers must -

(A) Meet all the provider requirements contained in the CHOICE guidelines as applicable to the provider;

(B) Be Qualified Contractors, Special Equipment Suppliers, Businesses, Agencies, Organizations, or Individuals; and

(C) Be knowledgeable of applicable standards of manufacturing, design, and installation of the specific device installed.

(5) Documentation requirements

(A) PERS must be provided in accordance with the written Plan of Care addressing specific needs determined by the individual's assessment.

(6) Billing requirements.

(A) PERS is billing depends on the funding source.

10051 Service Specific Provider Requirements – Pest Control Services

CHOICE providers of pest control services shall implement services in accordance with the requirements of this Section.
(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10052 Service Specific Provider Requirements – Respite Care

CHOICE providers of respite services shall meet specified requirements and develop and implement safety and security policies and procedures.
(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

Procedure.

(1) Respite Care services are those services that are provided temporarily or periodically in the absence of the usual caregiver.

(2) Respite Care may be provided in the following locations: in an individual's home, in the private home of the caregiver, in an adult foster care home, or in a Medicaid certified nursing facility.

(3) The level of professional care provided under respite care services depends on the needs of the client.

(A) A client requiring assistance with bathing, meal preparation and planning, specialized feeding, such as a client who has difficulty swallowing, refuses to eat, or does not eat enough; dressing or undressing; hair and oral care; and weight bearing transfer assistance should be considered for respite home health aide under the supervision of a registered nurse.

(B) A client requiring infusion therapy; venipuncture; injection; oral medication; Hoyer lift; wound care for surgical, decubitus, incision, and so forth; ostomy care; and tube feedings

should be considered for respite nursing services.

(4) Service Requirements/Allowable Activities:

(A) Homemaker services

(B) Attendant care

(C) Home health aide services

(D) Skilled nursing services

(E) Nursing facility services.

(5) Service authorization requirements:

(A) The case manager authorizes respite care, except when required to be provided in a nursing facility.

i The case manager is required to receive prior authorization from the Indiana Family and Social Services Administration (IFSSA) with a completed *Request for Approval to Authorize Services Form* before Respite Care may be provided in a nursing facility.

(6) Limitations/Exclusions

(B) Respite care shall not be used as day/child care to allow the persons normally providing care to go to work.

(C) Respite care shall not be used as day/child care to allow the persons normally providing care to attend school.

(D) Respite care shall not be used to provide service to a member while member is attending school.

(E) Respite care may not be used to replace skilled nursing services that should be provided under the Medicaid State Plan.

(F) Respite care must not duplicate any other service being provided under the individual's plan of care.

(G) If an individual's need for respite care services can be met by an LPN, but an RN provides the service, the service may only be billed at the LPN rate.

(4) Respite care providers must -

(A) Meet all the provider requirements contained in the CHOICE guidelines as applicable to the provider;

(B) Be a:

i Community Developmental Disabilities Agency; or

ii Licensed Home Health Agency; or

iii Medicaid Certified Nursing Facility; or

iv Individual.

(C) Family members who are providing caregiving to the participant may not be paid to provide respites services (since respite services are designed to relieve the caregiver during periods of brief absence from the individual).

(D) Providers must be qualified to provide the "level" of respite care services authorized by the case manager, or by FSSA DA for NF services.

(5) Documentation requirements

(A) Respite care must be provided in accordance with the written Plan of Care addressing specific needs determined by the individual's assessment.

(B) Documentation must include the following elements: the reason for the respite, the location where the service was rendered and the type of respite rendered. For example, respite Home Health Agency (HHA).

i Documentation should include date and time, and at least the last name and first initial of the respite care provider making the entry.

ii If the person providing the service is a professional, the title of the individual must also be included. For example, if a nurse is required to perform the service then the RN title would be included with the name.

(6) Billing requirements.

(A) Billing depends on the funding source.

10053 Service Specific Provider Requirements – Supplies

CHOICE providers of supplies shall implement services in accordance with the requirements of this Section.
(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10054 Service Specific Provider Requirements – Therapy Services

CHOICE providers of therapy services shall meet specified requirements and develop and implement safety and security policies and procedures specified in this Section.
(Authority IC 12-10-10; 460 IAC 1.2-9-6; 460 IAC 1.2-20-1; 460 IAC 1-4-11)

10055 Service Specific Provider Requirements – Transportation

CHOICE providers of transportation services shall meet specified requirements and develop and implement safety and security policies and procedures specified in this Section.
(Authority IC 12-10-10; 460 IAC 1.2-12-1; 460 IAC 1-4-11)

Procedure.

(1) The following provider types may be certified to provide transportation services:

(A) Qualified public and private carriers.

(B) Qualified individuals.

i Individual personnel providing transportation must meet the following requirements.

(a) Have a valid Operator's license under IC 9-24-3 for individuals using private vehicles.

(b) Have a valid Chauffeur's license under IC 9-24-4 or an Indiana Public Passenger Chauffeur's license when driving a vehicle designed to transport fewer than 15 people (IC 9-24-5).

(c) Have a valid Indiana Commercial Driver's license when operating a vehicle designed to transport a minimum of 15 people (IC 9-24-6).

(d) Have a safe, legal driving record.

(e) Have auto insurance, including liability insurance.

(f) Have properly licensed and maintained vehicles.

(2) An approved provider of transportation services or its agent shall do the following:

(A) Maintain the vehicle or vehicles used in the provision of transportation services in good repair.

(B) Retain and make available upon request, records of regular and appropriate maintenance.

(C) Assure the vehicle used for transportation services is properly registered:

i with the Indiana Bureau of Motor Vehicles; or

ii in the state in which the owner of the vehicle resides.

(D) Retain and make available upon request, documentation confirming the provider has the appropriate insurance as required under Indiana law.

10056 Service Specific Provider Requirements for Self-Directed In-Home Care

CHOICE funded services may only be provided by authorized service providers.
(Authority IC 12-10-10; 460 IAC 1-4-3; 460 IAC 1-4-11)

Procedure.

(1) An individual who is a legally responsible relative of an individual in need of self-directed in-home care, including a parent of minor individual and a spouse, is precluded from providing attendant care services for compensation.

(2) An individual may not provide attendant care services for compensation for an individual in

need of self-directed in-home care services unless the individual is registered.

(A) An individual who desires to provide attendant care services must register with the FSSA DA or with an organization designated by the division.

(B) The FSSA DA shall register an individual who provides the following:

i A personal résumé containing information concerning the individual's qualifications, work experience, and any credentials the individual may hold. The individual must certify that the information contained in the résumé is true and accurate.

ii The individual's limited criminal history check from the Indiana central repository for criminal history information under IC 10-13-3 or another source allowed by law.

(a) The limited criminal history check and report must be updated every two (2) years.

iii If applicable, the individual's state nurse aide registry report from the State Department of Health. This subdivision does not require an individual to be a nurse aide.

iv Three (3) letters of reference.

v A registration fee. The FSSA DA establishes the amount of the registration fee.

vi Proof that the individual is at least eighteen (18) years of age.

vii Any other information required by the FSSA DA.

(C) A registration is valid for two (2) years.

(3) A personal services attendant may renew the personal services attendant's registration by updating any information in the file that has changed and by paying the fee required under subsection.

(4) A personal services attendant who is hired by the individual in need of self-directed in-home care is an employee of the individual in need of self-directed in-home care.

(A) The division is not liable for any actions of a personal services attendant or an individual in need of self-directed in-home care.

(B) A personal services attendant and an individual in need of self-directed in-home care are each liable for any negligent or wrongful act or omission in which the person personally participates.

(5) The FSSA DA and any organization designated by the FSSA DA shall maintain a file for each personal services attendant that contains:

(A) comments related to the provision of attendant care services submitted by an individual in need of self-directed in-home care who has employed the personal services attendant; and

(B) the items described in subsection (2).

10057 Provider Requirements – Warranties

Warranties are required for applicable CHOICE-funded services.
(Authority IC 12-10-10; 460 IAC 1.2-18-1; 460 IAC 1-4-11)

Procedure.

(1) All applicable services provided to an individual under the CHOICE program including, but not limited to:

- durable medical equipment;
- personal emergency response system;
- home modification; and
- vehicle modifications;

shall supply a warranty effective for at least one (1) year from the date of new installation or the date the individual received the new item, whichever is applicable.

10058 Provider Monitoring

CHOICE providers are routinely monitored to ensure compliance with applicable requirements of this Chapter. Primary monitoring of CHOICE providers shall be a function of the Area Agencies on Aging.
(Authority IC 12-10-10; 460 IAC 1-4-11; 460 IAC 1.2, Section 4)

Procedure.

(1) FSSA DA periodically monitors CHOICE providers:

(A) As stated in the current executed contract or provider agreement.

(B) Upon receiving a complaint or report alleging a provider's noncompliance with the requirements of the CHOICE program.

i If a person other than an individual receiving service files a complaint, FSSA DA shall notify the person filing the complaint of completion of the following:

(a) FSSA DA monitoring as a result of the complaint.

(b) Any corrective action by the provider as a result of FSSA DA monitoring.

(C) As frequently as deemed necessary by FSSA DA.

(D) According to FSSA DA approved policy.

(2) FSSA DA monitors compliance with the requirements of the CHOICE program through any of the following means:

(A) Requesting and obtaining information from the provider.

(B) On-site inspections.

(C) Meeting with an individual or the individual's legal representative as applicable.

(D) Reviewing provider records and the records of an individual.

(E) Following-up on completed inspections, as frequently as deemed necessary by the FSSA DA, to determine compliance after submission of a corrective action plan by a provider to the FSSA DA.

(3) The provider will submit to the FSSA DA any requested documentation within ten (10) days from the date that the provider receives a report of findings unless otherwise specified.

(4) After an on-site inspection, FSSA DA shall issue a written report, which shall:

(A) Document the findings made during monitoring.

(B) Identify necessary corrective action.

(C) Give the provider ten (10) days in which to complete the corrective action plan unless otherwise specified.

(D) Identify documentation needed from the provider to support the provider's completion of the corrective action plan.

(E) Be submitted to the provider.

(5) A provider shall do the following:

(A) If requested, complete a corrective action plan to the reasonable satisfaction of FSSA DA within:

i the time period identified in the corrective action plan; or

ii another time period agreed upon by the FSSA DA.

(B) Notify FSSA DA upon the completion of a corrective action plan.

(C) Provide FSSA DA with all requested documentation.

10059 Provider Non-Compliance with Requirements

CHOICE providers who do not comply with CHOICE program requirements will be sanctioned up to and including decertification.
(Authority IC 12-10-10; 460 IAC 1-4-11; 460 IAC 1.2, Section 5)

Procedure.

(1) If a provider does not comply with the requirements of the CHOICE program or does not submit and complete an acceptable, approved corrective action plan to the reasonable satisfaction of FSSA DA within the time specified, FSSA DA shall not authorize either or both of the following:

(A) The continuation of services to an individual or individuals by the provider if the services do not comply with the specified requirements.

(B) The receipt of services by individuals not already receiving services from the provider at the time the determination is made that the provider did not implement a corrective action plan to the reasonable satisfaction of FSSA DA.

(2) The decertification process is initiated by the Area Agency on Aging and the FSSA DA will assist with the appeals process if necessary.

(3) FSSA DA shall give written notice of FSSA DA's action specific to provider non-compliance to the following:

(A) The provider.

(B) The individual receiving services from the provider.

(C) The individual's legal representative, if applicable.

(4) The written notice shall include the following:

(A) The CHOICE program requirements with which the provider has not complied.

(B) The effective date, with at least thirty (30) days notice, of FSSA DA's action specific to the non-compliance(s).

(C) The need for planning to obtain HCBS for an individual or individuals.

(D) The provider's right to seek administrative review of FSSA DA's action.

10060 Provider Non-Compliance with Requirements That Endangers the Health or Welfare of an Individual Such That an Emergency Exists

CHOICE providers are subject to special and expedited sanctions when the provider's noncompliance with CHOICE program requirements endangers the health or welfare of an individual such that an emergency exists.
(Authority IC 12-10-10; 460 IAC 1-4-11; 460 IAC 1.2, Section 6)

Procedure.

(1) If a provider's noncompliance with CHOICE program requirements endangers the health or welfare of an individual such that an emergency exists, as determined by FSSA DA or its designee, FSSA DA may enter an order for any of the following:

(A) Termination of continued authorization for the provider to:

i serve any individual whose health or safety is being seriously endangered; or

ii provide any services under a HCBS program.

(B) Denial of authorization for the receipt of services by individuals not already receiving services from the provider at the time FSSA DA determines that a provider's noncompliance with this article endangers the health or safety of an individual.

(2) Any action taken under subsection (1) shall remain in effect until such time FSSA DA determines the provider's noncompliance is no longer endangering the health or safety of an individual.

(3) FSSA DA shall give written notice of an order under subsection (1) to the following:

(A) The provider.

(B) The individual receiving services from the provider.

(C) The individual's legal representative, as applicable.

(4) The written notice shall include the following:

(A) The requirements of the CHOICE program with which the provider has not complied.

(B) A brief statement of the facts and the law leading to FSSA DA's determination that an emergency exists.

(C) The need to immediately obtain services that comply with this article for an individual or individuals.

(D) The provider's right to seek administrative review of FSSA DA's action.

(5) The order issued under subsection (1) shall expire on the earlier of the following:

(A) The date FSSA DA determines that an emergency no longer exists.

(B) Ninety (90) days.

(6) During the pendency of any related proceedings under IC 4-21.5, FSSA DA may renew an emergency order for successive ninety (90) day periods.

10061 Provider – Revocation of Approval

CHOICE provider approval may be revoked by the FSSA DA under specified circumstances. (Authority IC 12-10-10; 460 IAC 1-4-11; 460 IAC 1.2, Section 7)

Procedure.

(1) The FSSA DA may revoke the approval of a CHOICE provider for any of the following reasons:

(A) The provider's repeated noncompliance with CHOICE requirements.

(B) The provider's continued noncompliance with CHOICE requirements.

(C) The provider's noncompliance with CHOICE requirements that endangers the health or welfare of an individual.

10062 Provider Appeals

If a CHOICE provider has an executed contract or provider agreement to provide a service to an individual, the provider has the right to appeal decisions that adversely affect the service provider. (Authority IC 12-10-10; 460 IAC 1-4-11; 460 IAC 1.2-7-1)

Procedure.

(1) The service provider shall make a written request for an appeal hearing to the secretary of FSSA within fifteen (15) days of the date of an adverse decision.

(2) The request must:

(A) include a statement indicating with reasonable particularity the issue the service provider wishes to be reviewed; and

(B) be signed and dated by the service provider.

(3) Appeal proceedings will be conducted by a FSSA-appointed administrative law judge (ALJ) under IC 4-21.5.

(A) Notice of the ALJ's decision shall be sent also to any listed adversely affected party.

10063 HCBS Providers – Resolution of Disputes

If a dispute arises between or among providers, the dispute resolution process set out in this section shall be implemented.
(Authority IC 12-10-10; 460 IAC 1.2-9-3; 460 IAC 1-4-11)

Procedure.

(1) The resolution of a dispute shall be designed to address an individual's needs.

(2) The parties to the dispute and the individual shall attempt to resolve the dispute informally through an exchange of information and possible resolution.

(3) If these parties are not able to resolve the dispute within fifteen (15) calendar days, each party must document, in writing, the issues in the dispute, their positions and their efforts to resolve the dispute and the parties shall refer the dispute to FSSA DA or its designee for resolution in coordinating the individual's needs.

(4) The parties shall abide by the decision.

(5) A party adversely affected or aggrieved by FSSA DA's decision may request an administrative review of the decision under 460 IAC 1.2-7-1 within fifteen (15) calendar days after the party receives written notice of the recommendation.

    (A) Administrative review proceedings shall be conducted under IC 4-21.5.