SOUTHWEST
HEALTH & HUMAN
SERVICES

PLEASE NOTE
THE BOARD MEETING WILL BE HELD IN REDWOOD FALLS

Southwest Health and Human Services
Board Agenda
Wednesday, July 17, 2013
266 East Bridge Street (Public Health Office)
Redwood Falls
9:00 a.m.

HUMAN SERVICES

A. Call to order

B. Pledge of Allegiance

C. Consent Agenda
   1. Amend/Approval of Agenda
   2. Identification of Conflict of Interest
   3. Approval of 06/19/13 board minutes

D. Financial

E. Caseload

	06/13	05/13	04/13
Social Service	3314	3313	3309
Out-of-Home Placements	103	127	126
Income Maintenance	11,191	11,047	10,995
Child Support Cases	3835	3816	3846
Child Support Collections	$849,246	$917,183	$976,030

F. Decision Items
   1. Social Service Policy Number 12 – Fee: Detoxification
   2. Social Service Policy Number 15 – Waivered Services
   3. Social Service Policy Number 31 – Home and Community Based Waiver (HCBS) Consumer Directed Community Support (CDCS) Services

HUMAN SERVICES (cont.)

F. Decision Items (cont.)
   4. Social Service Policy Number 32 – Consumer Support Grant
   5. Social Service Policy Number 33 – CAC, CADI, and BI Waivered Services
   6. Social Services Policy Number 34 – Investigation: Maltreatment of a Vulnerable Adult

G. Discussion/Information
   1.
   2.

COMMUNITY HEALTH

H. Call to order

I. Consent Agenda
   1. Amend/Approval of Agenda
   2. Identification of Conflict of Interest
   3. Approval of 06/19/13 board minutes

J. Financial

K. Caseload

	06/13	05/13	04/13
WIC		2322	2270
Family Home Visiting	36	51	27
PCA Assessments	17	24	23
Managed Care	181	265	171
Dental Varnishing	79	126	77

L. Decision Items
   1.
   2.

M. Discussion/Information
   1. Food, Pools, and Lodging
   2. E-Connectivity grant
   3. Update on Oral Health Project

GOVERNING BOARD

N. Call to order

O. Consent Agenda
   1. Amend/Approval of Agenda
   2. Identification of Conflict of Interest
   3. Approval of 06/19/13 board minutes

P. Financial

Q. Introduce new staff member; Kayla Hall, Social Worker (CPS)

R. Decision Items
   1. Carol Biren, Community Health Services Manager, completion of 6 month probationary period, no salary increase, effective 07/14/13
   2. Kristin Malin, Social Worker Team Leader, completion of 6 month probationary period, no salary increase, effective 07/28/13
   3. Anita Van Veldhuizen, Office Support Specialist, probationary appointment (12 months), $15.50 per hour, effective 07/15/13
   4. Ann Abraham, Public Health Nurse, probationary appointment (12 months), $22.00 per hour, effective 07/15/13
   5. Cynthia Maxwell, Public Health Nurse, resignation, effective 07/26/13
   6. Kim Reynolds, Accounting Technician, resignation, effective 07/26/13
   7. Sarah Brustuen, Social Worker, resignation, effective 08/02/13
   8. Administrative Policy Number 19 – Remote Access
   9. Personnel Policy Number 2 – Conditions of Employment
   10. Personnel Policy Number 3 – Leaves and Holidays
   11. Memorandum of Understanding – Public Health & Human Services
   12. Contracts
   13. Copier lease - Pipestone
   14. Southwestern Minnesota Adult Mental Health Consortium – Amendment to Joint Powers Agreement
   15.
   16.
   17.

S. Discussion/Information
   1. Southern Prairie Community Care
   2. Labor update
   3.

T. Adjournment

SOUTHWEST HEALTH & HUMAN SERVICES

Ivanhoe, Marshall, Slayton, Pipestone, Redwood and Luverne Offices

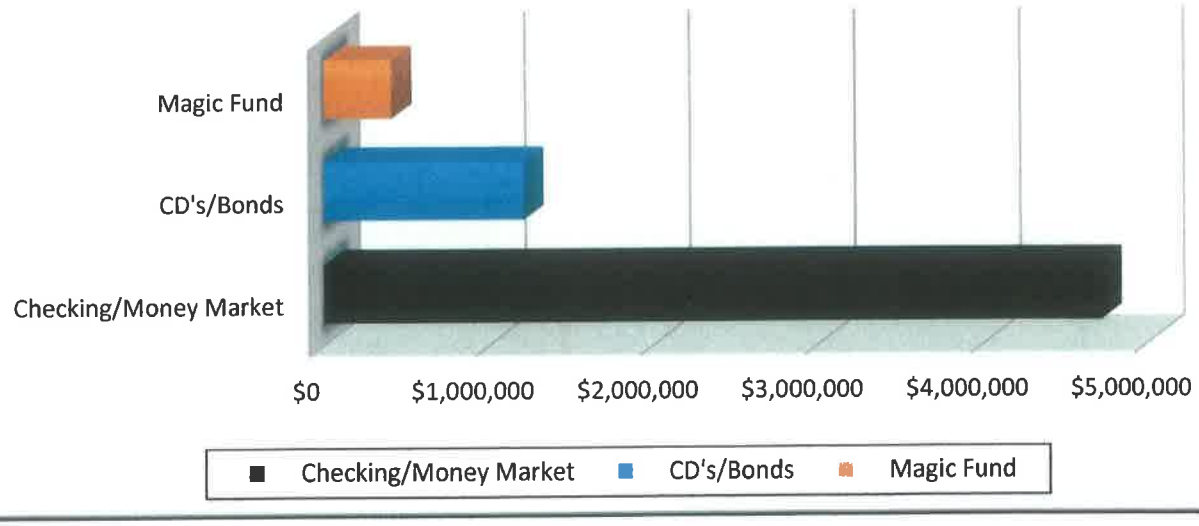
SUMMARY OF FINANCIAL ACCOUNTS REPORT For the Month Ending: **June 30, 2013**

*** Income Maintenance * Social Services * Information Technology * Health ***

Description	Month	Running Balance
BEGINNING BALANCE		**$4,068,939**
RECEIPTS		
Monthly Receipts	967,978	
County Contribution	2,954,862	
Interest on Investments	187	
TOTAL MONTHLY RECEIPTS		3,923,027
DISBURSEMENTS		
Monthly Disbursements	2,882,158	
TOTAL MONTHLY DISBURSEMENTS		2,882,158
ENDING BALANCE		**$5,109,808**

REVENUE			
Checking/Money Market	***$4,705,276***		**Average Balance last two years $6,099,252**
CD's/Bonds	***$1,200,000***		
Magic Fund	***$404,532***		
(June 2013 - yield .04%)			
ENDING BALANCE		**$6,309,808**	

REVENUE DESIGNATION



Southwest Health And Human Services

INTEGRATED FINANCIAL SYSTEMS

TREASURER'S CASH TRIAL BALANCE

As of 06/2013

Fund			Beginning Balance	This Month	YTD	Current Balance
1	Health Services Fund					
			1,118,213.24			
	Receipts			171,382.08	1,979,802.68	
	Disbursements			170,141.04-	661,523.08-	
	Payroll			166,662.02-	1,038,146.99-	
	Journal Entries			100,000.00-	101,243.30-	
	Fund Total			265,420.98-	178,889.31	1,297,102.55
5	Human Services Fund	410	General Administration			
			306,970.30			
	Receipts			217,556.65	1,380,689.69	
	Disbursements			232,555.26-	1,508,166.95-	
	Payroll			3,300.57-	8,876.83-	
	Dept Total			18,299.18-	136,354.09-	170,616.21
5	Human Services Fund	420	Income Maintenance			
			1,478,708.43-			
	Receipts			834,498.51	3,648,288.01	
	Disbursements			215,112.30-	1,492,225.21-	
	Payroll			318,496.02-	1,981,385.39-	
	Journal Entries			162,009.86-	322,009.86-	
	Dept Total			138,880.33	147,332.45-	1,626,040.88-
5	Human Services Fund	430	Social Services			
			24,236,915.12-			
	Receipts			1,450.51	88,539.90	
	Disbursements			64,092.23-	677,825.71-	
	Payroll			465,877.87-	2,839,278.58-	
	Journal Entries			240,000.00-	480,000.00-	
	Dept Total			768,519.59-	3,908,564.39-	28,145,479.51-
5	Human Services Fund	431	Purchased Services,SSIS			
			31,296,082.32			
	Receipts			2,650,872.52	7,386,169.02	
	Disbursements			7,324.50-	308,700.31-	
	SSIS			635,217.33-	3,684,951.78-	

Southwest Health And Human Services

TREASURER'S CASH TRIAL BALANCE

As of 06/2013

Fund		Beginning Balance		This Month	YTD	Current Balance
	Journal Entries			0.00	0.02	
	Dept Total			2,008,330.69	3,392,516.95	34,688,599.27
5	Human Services Fund		461	Information Systems		
		1,408,795.11-				
	Receipts			10,560.87	47,279.72	
	Disbursements			1,064.59-	22,592.02-	
	Payroll			20,165.33-	111,648.50-	
	Dept Total			10,669.05-	86,960.80-	1,495,755.91-
5	Human Services Fund		471	LCTS Collaborative Agency		
		0.00				
	Receipts			0.00	80,044.00	
	Journal Entries			0.00	80,044.00-	
	Dept Total			0.00	0.00	0.00
	Fund Total			1,349,723.20	886,694.78-	3,591,939.18
71	LCTS Lyon Murray Collaborative Fund		471	LCTS Collaborative Agency		
		73,752.45				
	Receipts			0.00	18,355.67	
	Disbursements			0.00	24,815.00-	
	Journal Entries			0.00	25,538.33	
	Dept Total			0.00	19,079.00	92,831.45
	Fund Total			0.00	19,079.00	92,831.45
73	LCTS Rock Pipestone Collaborative Fund		471	LCTS Collaborative Agency		
		64,830.53				
	Receipts			0.00	15,920.69	
	Disbursements			0.00	55,646.04-	
	Journal Entries			0.00	12,624.67	
	Dept Total			0.00	27,100.68-	37,729.85
	Fund Total			0.00	27,100.68-	37,729.85

Southwest Health And Human Services

TREASURER'S CASH TRIAL BALANCE

As of 06/2013

Fund		Beginning Balance		This Month	YTD	Current Balance
75	Redwood LCTS Collaborative		471	LCTS Collaborative Agency		
		0.00				
	Receipts			36,706.80	192,910.90	
	Disbursements			80,140.00-	144,586.26-	
	Journal Entries			0.00	41,881.00	
	Dept Total			43,433.20-	90,205.64	90,205.64
	Fund Total			43,433.20-	90,205.64	90,205.64
All Funds		5,735,430.18				
	Receipts			3,923,027.94	14,838,000.28	
	Disbursements			770,429.92-	4,896,080.58-	
	SSIS			635,217.33-	3,684,951.78-	
	Payroll			974,501.81-	5,979,336.29-	
	Journal Entries			502,009.86-	903,253.14-	
	Total			1,040,869.02	625,621.51-	5,109,808.67

Southwest Health And Human Services

INTEGRATED FINANCIAL SYSTEMS

TRIAL BALANCE REPORT

As of 06/2013 Report Basis: Cash

1 Health Services Fund

Account			Beginning Balance	Actual This- Month	Actual Year- To- Date	Current Balance
		----------Assets----------				
1001	Cash		1,118,213.24	265,420.98-	178,889.31	1,297,102.55
1090	Investments		300,000.00	100,000.00	100,000.00	400,000.00
		Total Assets	1,418,213.24	165,420.98-	278,889.31	1,697,102.55
		---Liabilities and Balance-----				
		Liabilities				
		Total Liabilities	0.00	0.00	0.00	0.00
		Fund Balance				
2881	Unassigned Fund Balance		1,418,213.24-	0.00	0.00	1,418,213.24-
2885	Revenue Control		0.00	171,382.07-	1,967,739.85-	1,967,739.85-
2887	Expenditure Control		0.00	336,803.05	1,688,850.54	1,688,850.54
		Total Fund Balance	1,418,213.24-	165,420.98	278,889.31-	1,697,102.55-
		Total Liabilities and Balance	1,418,213.24-	165,420.98	278,889.31-	1,697,102.55-
410	General Administration					
		----------Assets----------				
		Total Assets	0.00	0.00	0.00	0.00
		---Liabilities and Balance-----				
		Liabilities				
		Total Liabilities	0.00	0.00	0.00	0.00
		Total Liabilities and Balance	0.00	0.00	0.00	0.00
1	Health Services Fund		0.00	0.00	0.00	0.00

Southwest Health And Human Services

INTEGRATED FINANCIAL SYSTEMS

TRIAL BALANCE REPORT
As of 06/2013 Report Basis: Cash

Account		Beginning Balance	Actual This- Month	Actual Year- To- Date	Current Balance
410	General Administration				
	----------Assets----------				
1001	Cash In Bank - Checking	306,970.30	18,299.18-	136,354.09-	170,616.21
1090	Investments	0.00	400,000.00	800,000.00	800,000.00
	Total Assets	306,970.30	381,700.82	663,645.91	970,616.21
	---Liabilities and Balance-----				
	Liabilities				
2080	Medical Insurance Payable	169,148.56-	513.50	122,910.25	46,238.31-
2090	Due To Flexible Plan Employees	0.00	368.59-	984.18-	984.18-
	Total Liabilities	169,148.56-	144.91	121,926.07	47,222.49-
	Fund Balance				
2881	Unassigned Fund Balance	137,821.74-	400,000.00-	800,000.00-	937,821.74-
2885	Revenue Control	0.00	0.00	59,711.55-	59,711.55-
2887	Expenditure Control	0.00	18,154.27	74,139.57	74,139.57
	Total Fund Balance	137,821.74-	381,845.73-	785,571.98-	923,393.72-
	Total Liabilities and Balance	306,970.30-	381,700.82-	663,645.91-	970,616.21-
420	Income Maintenance				
	----------Assets----------				
1001	Cash In Bank - Checking	1,478,708.43-	138,880.33	147,332.45-	1,626,040.88-
	Total Assets	1,478,708.43-	138,880.33	147,332.45-	1,626,040.88-
	---Liabilities and Balance-----				
	Liabilities				
	Total Liabilities	0.00	0.00	0.00	0.00
	Fund Balance				
2881	Unassigned Fund Balance	1,478,708.43	160,000.00	320,000.00	1,798,708.43
2885	Revenue Control	0.00	830,922.91-	3,587,328.44-	3,587,328.44-
2887	Expenditure Control	0.00	532,042.58	3,414,660.89	3,414,660.89
	Total Fund Balance	1,478,708.43	138,880.33-	147,332.45	1,626,040.88
	Total Liabilities and Balance	1,478,708.43	138,880.33-	147,332.45	1,626,040.88
430	Social Services				

Southwest Health And Human Services

STATEMENT OF REVENUES AND EXPENDITURES

As Of 06/2013 Report Basis: Cash

DESCRIPTION	CURRENT MONTH	YEAR TO-DATE	2013 BUDGET	% OF BUDG	% OF YEAR
FUND 1 HEALTH SERVICES FUND					
REVENUES					
CONTRIBUTIONS FROM COUNTIES	14,530.50-	388,361.00-	776,722.00-	50	50
INTERGOVERNMENTAL REVENUES	465.00-	432,049.76-	463,292.00-	93	50
STATE REVENUES	32,460.17-	300,122.52-	296,342.00-	101	50
FEDERAL REVENUES	67,064.18-	507,388.98-	890,960.00-	57	50
FEES	22,191.44-	249,366.36-	443,780.00-	56	50
EARNINGS ON INVESTMENTS	37.49-	721.85-	0.00	0	50
MISCELLANEOUS REVENUES	34,633.29-	89,729.38-	178,500.00-	50	50
TOTAL REVENUES	171,382.07-	1,967,739.85-	3,049,596.00-	65	50
EXPENDITURES					
PROGRAM EXPENDITURES	0.00	0.00	0.00	0	50
PAYROLL AND BENEFITS	166,662.02	1,038,146.99	2,245,694.00	46	50
OTHER EXPENDITURES	170,141.03	650,703.55	803,902.00	81	50
TOTAL EXPENDITURES	336,803.05	1,688,850.54	3,049,596.00	55	50

Southwest Health And Human Services

STATEMENT OF REVENUES AND EXPENDITURES

As Of 06/2013 Report Basis: Cash

DESCRIPTION	CURRENT MONTH	YEAR TO-DATE	2013 BUDGET	% OF BUDG	% OF YEAR
FUND 5 HUMAN SERVICES FUND					
REVENUES					
CONTRIBUTIONS FROM COUNTIES	2,940,332.31-	3,722,366.87-	9,088,387.00-	41	50
INTERGOVERNMENTAL REVENUES	12.50-	1,867,506.38-	325,058.00-	575	50
STATE REVENUES	31,836.43-	1,153,588.90-	3,492,352.00-	33	50
FEDERAL REVENUES	288,020.48-	3,054,272.91-	6,181,865.00-	49	50
FEES	135,947.52-	657,963.09-	1,135,250.00-	58	50
EARNINGS ON INVESTMENTS	149.98-	922.65-	1,300.00-	71	50
MISCELLANEOUS REVENUES	87,931.99-	675,231.90-	1,436,067.00-	47	50
TOTAL REVENUES	3,484,231.21-	11,131,852.70-	21,660,279.00-	51	50
EXPENDITURES					
PROGRAM EXPENDITURES	753,105.73	4,730,527.72	9,322,653.00	51	50
PAYROLL AND BENEFITS	798,096.91	4,929,918.29	10,202,186.00	48	50
OTHER EXPENDITURES	183,160.46	1,355,425.93	2,135,440.00	63	50
TOTAL EXPENDITURES	1,734,363.10	11,015,871.94	21,660,279.00	51	50

SOUTHWEST HEALTH AND HUMAN SERVICES CHECK REGISTER

JUNE 2013

DATE	RECEIPT or CHECK #	DESCRIPTION	+ DEPOSITS	-DISBURSEMENTS	BALANCE
	BALANCE FORWARD				4,068,939.65
6/3/13	31685-31689	DISB		1,429.38	4,067,510.27
6/3/13	31690-31729	DISB		25,866.13	4,041,644.14
6/4/13	3426-3449, 3454	Dep	13,068.48		4,054,712.62
6/4/13	JE240(Purchase Bond)	DISB		500,000.00	3,554,712.62
6/6/13	3512	Dep	1,097,555.00		4,652,267.62
6/7/13	3450-3453, 3455-3511, 3513-3539	Dep	196,093.96		4,848,361.58
6/10/13	31730-31783	DISB		4,665.09	4,843,696.49
6/11/13	3540-3570	Dep	202,057.69		5,045,754.18
6/10/13	31784-31965	DISB		505,940.41	4,539,813.77
6/14/13	5947-5961	PAYROLL		485,787.06	4,054,026.71
6/14/13	3571-3599, 3603-3631	Dep	208,214.00		4,262,240.71
6/17/13	31966-32023	DISB		24,905.07	4,237,335.64
6/17/13	32024-32225 1 -1 ACH	DISB		402,434.30	3,834,901.34
6/18/13	3599-3602,3632-3666	Dep	21,614.03		3,856,515.37
6/21/13	32226 - 32518			74,274.73	3,782,240.64
6/24/13	32519-32567	DISB		7,849.91	3,774,390.73
6/21/13	3667-89,3691-3752,3757-58,3760-3763	Dep	106,510.29		3,880,901.02
6/24/13	32568-32677	DISB		291,076.79	3,589,824.23
6/24/13	79151	Dep	1,334,514.03		4,924,338.26
6/25/13	3753-56, 3759, 3764,3766-3826	Dep	532,715.18		5,457,053.44
6/28/13	5962-5983	PAYROLL		488,714.75	4,968,338.69
6/28/13	32678-32715	DISB		3,160.31	4,965,178.38
6/28/13	32716-32794	DISB		64,045.13	4,901,133.25
6/28/13	3827-3867,3874-3887	Dep	210,497.81		5,111,631.06
6/5/13	78903	Int (May)	28.43		5,111,659.49

6/5/13	78904	Int (May)	21.16		5,111,680.65
6/5/13	78905	Int (May)	137.88		5,111,818.53
6/27/13	JE241(Neg Payroll)	DISB		1,963.12	5,109,855.41
6/27/13	JE242(Neg Payroll)	DISB		46.74	**5,109,808.67**
7/1/13	Balanced by TPK	**TOTALS**	**3,923,027.94**	**2,882,158.92**	

SOUTHWEST HEALTH AND HUMAN SERVICES
SOCIAL SERVICE POLICY NUMBER 12

EFFECTIVE DATE: 08/17/11
REVISION DATE: 07/17/13
AUTHORITY: Southwest Health and Human Services - Human Services Board
Minnesota Statute 254a.08
~~Minnesota Statute 256e.08, Subd. 6~~
Minnesota Statute 393.12

--- FEE: DETOXIFICATION ---

Section 1 - Purpose

a. Minnesota Statute 254a.08 requires ~~Lincoln, Lyon and Murray Counties~~ Southwest Health and Human Services (SWHHS) to provide detoxification services for ~~drug~~ chemically dependent persons. Individuals in these counties needing detoxification will be provided the service. The county in which the individual is found needing the service will be financially responsible for the service.

b. Minnesota Statute ~~256e.08, Subd.6~~ 393.12 allows ~~Lincoln, Lyon, and Murray Counties~~ a county human services board to charge fees for social services furnished to a family or individual not on public assistance. ~~to establish a schedule of fees, based upon the consumer's ability to pay, to be charged to recipients of detoxification services.~~

~~c. Minnesota Statute 393.12 also allows a county Human Services Board to charge fees for social services furnished to a family or individual not on public assistance.~~

c.~~d~~. It is the policy of Southwest Health and Human Services to charge the cost of detoxification fees using our detoxification fee schedule for services delivered to fee eligible consumers of detoxification services as well as full-pay individuals. These services will include all costs associated with the transportation and services while at the detoxification facility. Southwest Health and Human Services currently contracts with New Life Treatment Center, Brown County Evalulation Center, and Project Turnabout for detoxification services.

d. Should the service provider charge a service fee to the agency for any additional costs, such as insurance processing fees, the agency will collect these fees from the consumer.

Section 2 - Income/Fee Determination

a. At the time of discharge from the detoxification facility, the consumer will be given a Detoxification Fee Determination form to be completed and returned to Southwest Health and Human Services. The individual may be eligible for a reduced fee depending on the annual income and the household size. If the individual is married, the spouse's income is considered when determining the fee. The household size consists of the individual, spouse, and children up to age 18 who are still attending high school.

b. The Detox Fee for juveniles (age 17 or under) is the responsibility of the parents or guardian.

c. If Southwest Health and Human Services is unable to determine the individual's income, a request will be sent asking for information regarding the most recent federal tax return, income for the last three months, household size, and insurance coverage for detoxification services. If the individual does not respond to the request and provide the requested information, Southwest Health and Human Services will automatically bill the individual for the full cost of the detoxification.

d. It is the individual's responsibility to provide all insurance information necessary to submit a claim to the insurance provider. If the insurance provide coverage for this fee but does not pay in full, the individual will be billed for the remaining balance. If the individual qualifies for the reduced fee, he/she will be billed for the remaining balance up to the reduced fee.

~~e. MN Statute 2563.08 authorizes Southwest Health and Human Services to establish a fee schedule based upon a client's ability to pay for services provided to recipients of community social services.~~

SOUTHWEST HEALTH AND HUMAN SERVICES
SOCIAL SERVICE POLICY NUMBER 15

EFFECTIVE DATE: 08/17/11
REVISION DATE: 07/17/13
AUTHORITY: Southwest Health and Human Services – Human Services Board
MN Statute 256B.0916

--- WAIVERED SERVICES: ---
PRIORITIZE CLIENTS TO RECEIVE SERVICES, ESTABLISH A ~~MR~~DD/RC WAITING LIST AND RESERVE FUND

Section 1 - Purpose

a. This policy defines the aggregate financial management, the process of selecting consumers who will receive ~~MR~~DD/RC Waivered services, and the establishment of a Wait List. The process to resolve any conflicts about resource utilizations shall be the appeals process. SWHHS will not exceed the aggregate total allowable budget.

b. Southwest Health and Human Services is not able to serve all eligible persons requesting ~~MR~~DD/RC Waivered services. This policy describes the process and selection procedures for an individual to obtain funding from the ~~MR~~DD/RC Home and Community-Based Waiver. Individuals who are eligible to receive waivered services through the ~~MR~~DD/RC Waiver will be placed on a wait list until DHS announces allocations to Southwest Health and Human Services or the cost of services to the individual is manageable within the aggregate budget. The goals of the ~~MR~~DD/RC Waiver Program are to provide necessary services and supports that are meaningful to the person receiving the services, respectful of the person's beliefs and customs, and are cost-effective. Waivered services are different from institutional care services in that they are uniquely developed based on a person's needs and are available or can be developed in the community. Waivered services help a person to become involved in the community where he or she lives and works and to develop skills to be as independent as possible.

Section 2 - Eligibility Determination

a. All potential DD~~MR~~/RC waiver recipients must choose ~~MR~~DD/RC wavier services and be determined to be eligible for the ~~MR~~DD/RC waiver based on the following criteria:

- Be eligible for MN MA based on a disability diagnosis.
- Have a diagnosis of mental retardation or related condition.
- Be determined by screening team to be eligible for ICF/~~MR~~DD services/expected to be placed in an ICF/~~MR~~DD if home and community based services are not provided.
- Require daily interventions, daily service needs and a 24 hour plan of care that is specified in the ISP.

- Has an assessed need for supports and services over an above those available through regular Medical Assistance.

b. Documentation of each of the listed eligibility criteria will be written in the CSP and kept in the consumer's county file. Annual reviews and reauthorization of services must be completed. This review and reassessment and/or reauthorization is intended to verify continued eligibility for services. Included in the review will be a review of the individual's level of care and a determination of whether current services are sufficiently meeting the needs identified in the services plan.

Section 3 - Procedures

a. In accordance with the screening process described in the ~~Disability Service Program~~ Community Based Service Manual located at the DHS website the county social worker will convene a screening team to evaluate the level of care needed for each person on their case load. The screening will accurately reflect the level of needs and the supports for each person. If a new client, the screening will occur within sixty working days of when the person or their legal representative requests services. The social worker will complete an annual review or reconvene the screening team as needed. At the initial screening and upon request, the case manager will:

- Describe alternative funding sources and refer as appropriate.
- Inform person of MA state plan services.
- Describe other resources in the community.

b. The results of the screening will be recorded on the DD Screening Document, DHS-3067 (~~10-986~~-11) or most current version and submitted to DHS via MMIS (or MnChoices assessment tool when implemented). DHS will review initial full-team screening and either approve or deny the level of care. If denied, the client may appeal the decision.

c. Clients who have been approved for ICF/~~MR~~DD level of care and meet the ~~MR~~DD/RC eligibility requirements are eligible to be placed on the County Waiver Waiting List.

d. The case manager will use the urgency of need index on the screening document to identify the immediacy of the recipient's need for the waiver. This information will be used by the county in managing the waiting list.

Section 4 - Prioritization of and the Awarding of Allocations and Resources

a. When SWHHS receives waiver allocations or is able to manage the cost of ~~services~~ reuse slots within the aggregate budget, the case managers first meet together to discuss potential recipients they work for. After that meeting, the case managers meet with the waiver manager to present the consumers that they have determined to meet one or

all of the criteria of the priorities listed in this policy. Priority is given to those in crisis and those at risk of out-of-home placement. The county will assure that appropriate consideration is given to those on the waiting list regardless of the intensity of individual needs. The supervisor, based on information presented informs the case managers of the decision about who receives the waiver slot or the approval of funds in the aggregate budget.

b. When a consumer's needs change and more funding is needed to meet their needs, the case manager meets with the waiver coordinator to discuss those needs and if there is funding in the county budget, the request is approved. The following criteria are used to award resources:

- Increases in service authorizations to assure the health and safety of current recipients.
- New slot allocations and the necessary funding based on the individual's needs.
- Existing resources and the necessary funding based on the individual's needs.
- Increases in service authorizations for reasons other than health and safety needs of current recipients.

Section 5 - Process for Decision-Making

a. ~~MR~~DD/RC waivered services will only be authorized for persons who have been screened, determined eligible, and authorized by MA payment for the provision of home and community-based services whose projected services as identified through the screening document and ISP can be managed within the county's ~~MR~~DD/RC waiver resources. Case managers must annually redetermine the recipient's eligibility for the ~~MR~~DD/RC waiver. No services received by ~~an~~a ~~MR~~DD/RC waiver recipient will be paid through county dollars.

b. A case manager will assess potential recipients on the waiting list that have requested services within one year.

c. A case manager will consider:

- Individuals living in unstable living conditions due to age or incapacity (death, abandonment, life threatening condition with poor prognosis of recovery, sudden loss) of the primary caregiver.
- Individuals at risk of being placed out-of-home (natural or other disaster, removal from unsafe family situation). A need for service to avoid out-of-home placement of children.
- Persons at imminent risk (within 30 days) of admission to an ICF/~~MR~~DD for ~~MR~~DD/RC ~~(~~who, without provision of Waivered services, person would enter immediately into ICF/~~MR~~DD facility.
- ~~Emergency situations and the need to hold back resources.~~

- ~~Stabilizing a current living situation with supports.~~
- ~~Length of time on the waiting list in combination with the priorities listed.~~
- Meet other priorities established by the department.
- Require protection from confirmed abuse, neglect, or exploitation.
- A sudden closure of their current living arrangement.
- Moving from an institution due to bed closures.

d. The county will establish resource amounts based on documented past experience and projected needs for the coming year based on:
   - Historical spending
   - Recipient utilization history
   - Anticipated recipient needs
   - Emergency needs of recipients

e. All situations involving a request for expenditures of the Reserve Fund will be reviewed as they occur. The county will re-evaluate reserve resource needs on a quarterly basis.

f. A case manager will also ensure consumers are informed of choice of living arrangements. SWHHS helps people receive supports in the least restrictive and most integrated community alternatives possible. (Olmstead Decision and Americans with Disabilities Act)

g. County personnel will utilize and monitor the entire waiting list in assessing and planning for future needs of potential recipients. While people are waiting to access the waiver, case managers will ensure that the recipient is informed of other sources available for support. Case managers will also assist the consumer in exploring other possible funding sources as well as any possible natural supports.

h. The ~~MR~~DD/RC waiver cannot pay for services and goods that are the responsibility of another funding source (i.e. school, State Plan Medical Assistance, private insurance, etc.). The ~~MR~~DD/RC waiver will not pay for costs that are a normal parental responsibility. Southwest Health and Human Services will not pay for services above and beyond the annual county waiver budget determined by DHS.

i. Southwest Health and Human Services will review and consider the following in the decision to allocate new allocations and resources:
   - Can the necessary supports and services in the CSP be accommodated by the waiver budget?

- Can Southwest Health and Human Services assure the health, safety, and welfare of the consumer and reasonably assure health, safety and welfare into the future?
- Can Southwest Health and Human Services and consumer access providers who meet standards and competency requirements stated in the CSP?
- Does Southwest Health and Human Services anticipate having a surplus at the end of the budget year?
- What budget reserves will be needed to meet anticipated or unanticipated changes in current recipient needs with the budget year?
- Southwest Health and Human Services considers its historical spending data and trends; the demographics of its current waiver population; and recent changes in
  law or other service programs that could increase demand for waiver services among current recipients.
- How will turnover in the programs impact the budget of the county?
- SWHHS will consider the feasibility of adding new recipients on the basis of current anticipated needs of consumers, balance against the urgent need to those who are waiting for services.

j. Changes to individual service authorizations:

- Are discussed and agreed upon as part of the service planning process, using guidelines the county has established.
- Do not reduce medically necessary services needed to ensure the health and safety of the consumer.
- Do not reduce services needed to meet the objectives of the Community Support Plan and must be provided within the limits the county has agreed to in the support plan. Services that are desirable merely because they provide an enhanced quality of life above what is necessary do not have to be funded, but must be agreed to in the support plan.
- Proposed based on assessed individual need.

Section 6 - Service Coordination/Community Support Plan

a. SWHHS along with the consumer and if appropriate the guardian/representative shall develop a Community Support Plan. Once the Community Support Plan is agreed upon, it must be signed by the consumer, conservator/guardian if applicable and the service coordinator. The plan will:

- Accurately reflect the consumer's needs and levels of support based on assessed needs.
- Reasonably assure the person's health and safety.

- Describe all services, including informal and unpaid services that assist the person.
- Describe the type, amount, scope and duration of services and supports to be authorized.
- Describe the needs for any specialized oversight (i.e. nursing services).
- Describe services that are not yet available (other than services necessary to assure the health and safety of the person), due to funding or other resource limitations.

b. Whenever there is a change of eligibility or significant ~~changes in~~change in the needs or services planned, a new screening is required and the community support plan will be modified to include the new information about necessary services to assure the health and safety of the individual. Changes to the community support plan are made:
   - Based upon an evaluation of current need for funded supports and services.
   - With the assurance that the plan continues to meet the health and safety needs of the individuals.
   - In compliance with "Appeal/Notification Rights" section of this document for reductions not agreed to by the individual.

c. SWHHS is the sole provider of service coordination responsibilities. There is no need for documentation to neither designate the lead agency nor need for policy language to address how ongoing services will be coordinated between two or more agencies.

d. There are times when another county may be responsible for providing services coordination to a waiver recipient. The means to communicate needs is through a request for Service Arrangement authorization for services and a copy of the CSP to document the need for the level of services requested. This will be addressed by requesting a Service Arrangement authorization for services and a copy of the CSP to document the need for the level of services requested.

Section 7 - Health and Safety

a. The community support plans will identify the provision of the medically necessary services for the health and safety of the individual. The community support plan will include standards, training and competencies needed in addition to minimally established state standards in order to deliver the necessary services for the individual. SWHHS has documentation that providers meet all licensure and certification standards and other qualifications or standards identified in the ISP. The providers must deliver the services identified and required in the contract and the ISP. SWHHS will monitor provider's performance per contract and service provision and if needed will take corrective actions. SWHHS will comply with their obligations under law with regard to child or adult protection by reviewing reports from other regulatory agencies and will

take action when necessary to assure vulnerable people are protected. Any change in the authorized services for an individual may not reduce services assessed as needed to assure the individual's health and safety.

Section 8 - Financial Accountability

a. SWHHS must not spend in excess of its budget allocation for the calendar year. The individual authorizations are based on assessed needs identified in the ISP. Resource amounts added to the county budgets are neither an entitlement for the person nor a cap. Spending must be within the total allowable budget allocation for the county. Changes to individual services authorizations will:

- Be proposed on the basis of assessed individual need.
- Be discussed and agreed upon as a part of the services planning process.
- Not reduce medically necessary services needed to insure the health and safety of the individual.
- Not reduce services that are needed to meet the objectives of the community support plan and must be provided within the limits the county has agreed to in the support plan. Services that are desirable merely because they provide an enhanced quality of life above what is necessary to not have to be funded, but must be if agreed to in the support plan.
- Not reduce services without complying with the notification and other requirements described in the "Appeal/Notification Rights" section of this document.

b. Current recipients who meet all eligibility requirements must not be terminated from the waiver for the sole purpose of the agency's management of the waiver budget allocation. Goods and services must be the least costly that reasonably meet the individual's identified needs. The goods and services must be for the sole benefit of the person. While others may derive an indirect benefit, the reason for the purchase must be directly related to an assessed need of the individual. A prior authorization process will be completed as required for waiver services. SWHHS documents the services by entering and approving a service arrangement in MMIS. SWHHS will maintain records for possible audits. The ~~MR~~DD/RC Waiver Management System will be used for information on the allocated budget. Information from the system will be used as a resource in making decisions.

c. County Reserve Amount
Southwest Health and Human Services ~~established~~ establishes a 2.5% balance of the annual budget ~~in 2007~~ for unexpected expenditures through the ~~MR~~DD/RC Waiver Program. This balance will be used to provide unanticipated client needs for services such as an increase in services or crisis services. The funds will be utilized to assure that health and safety needs of all ~~MR~~DD/RC recipients are met.

d. The program expenditures for a consumer's services may not be increased without approval by the agency ~~MR~~DD/RC waiver coordinator. Any requested increase will be manageable within the county ~~MR~~DD/RC waiver budget.

e. Equal access to services shall be provided without regard to race, religion, gender, ethnic background, or age. All consumers or their representatives will have Social Service Policy Number 15 reviewed with them at the time of the annual review. When new cases are opened for services, the case manager will review Social Service Policy Number 15 with them. When requests are made to utilize the Reserve Fund, documentation must be made in the case file.

f. The Reserve Fund may be used to:
- Prevent admission to a treatment center or a more restrictive setting.
- Respond to unanticipated needs for respite and support.
- Protect consumers' health and safety needs.
- Respond to injury, illness, or death of a primary caregiver.
- Respond to the determination that the consumer is at risk and in need of protection or emergency services.

g. The Reserve Fund may be used for short-term (usually not to exceed three months) crisis or emergency situations. The resources of the Reserve Fund are intended for the consumers with the greatest needs.

h. It is the case manager's responsibility to inform recipients of the right to appeal any decisions concerning utilization of the Reserve Fund. All situations involving a request for use of Reserve Funds must be authorized by the social services supervisor.

Section 9 - Appeal/Notification Rights

a. If changes are made to a person's community support plan and services, all applicable notification and appeal rights apply. The Services Coordinator is responsible for informing applicant/recipient of appeal rights and this will documented in the file. When SWHHS is evaluating denials, modification, reductions or terminations of home and community-based services ~~under MN Statutes, section 256B.0926~~ for an individual, the case manager must offer to meet with the individual or individual's guardian in order to discuss the prioritization of service needs within the individual's community support plan. In the event of an appeal that is filed within 10 days of receiving the notice and the request for a continuation of benefits is made, waiver services (within the federal waiver plan parameters) must continue until there is a decision made about the appeal or unless the parties can reach agreement.

SOUTHWEST HEALTH AND HUMAN SERVICES
SOCIAL SERVICE POLICY NUMBER 15

Section 10 - Quality Assurance

a. The county will submit a biennial county plan for quality assurance in Home and Community Based Services. The "Health and Safety" section of this document gives additional information related to county responsibilities for quality assurance. SWHHS will solicit regular feedback from recipients on quality and satisfaction with services including service coordination. SWHHS will complete regular review of service system performance and needs identified. SWHHS will act upon Quality Assurance recommendations for improvement.

b. Southwest Health and Human Services included discovery, remediation and continuous improvement across the following seven domains of the Home and Community-based waiver service program:

- Participant Access
- Participant-Centered Services Planning and Delivery
- Provider Capacity and Capabilities
- Participant Safeguards
- Participant Rights and Responsibilities
- Participant Outcomes and Satisfaction
- Systems Performance

SOUTHWEST HEALTH AND HUMAN SERVICES
SOCIAL SERVICE POLICY NUMBER 31

EFFECTIVE DATE: 07/17/13
REVISION DATE:
AUTHORITY: Southwest Health and Human Services – Human Services Board
Federally Approved Waiver Plan
MN Statute 256.B

--- HOME AND COMMUNITY BASED WAIVER (HCBS) CONSUMER DIRECTED COMMUNITY SUPPORT (CDCS) SERVICES --- POLICIES AND PROCEDURES

Section 1 - Purpose

a. This policy defines the process to administer the Consumer Directed Community Support service through the Home and Community Based Waiver (HCBS). Southwest Health and Human Services (SWHHS) will provide CDCS service to eligible recipients who have chosen this option through the screening process and will provide it in accordance with the guidelines and procedures outlined below.

b. Individuals will be informed of their option to choose Consumer Directed Community Supports as one of the services offered through the HCBS waivers. If the consumer chooses the CDCS option all of their service needs must be met within the DHS assigned budget.

Section 2 – Service Description

a. Home and Community Based Waivers provide support, care, and assistance to individuals with disabilities or chronic illness who meet the eligibility criteria and level of care requirements for each waiver. Waivers prevent institutionalization and allow consumers to live an inclusive community life. Waivers are not entitlement program.

b. Provision of services and supports which assist the person, family, or friends to:
- Identify and access formal and informal support systems;
- Develop a meaningful consumer support plan; or
- Increase and/or maintain the capacity to direct formal and informal resources.

c. Completion of activities that assist the person, his/her family, or his/her friends to determine his/her future.

d. Development of person-centered support plans which provide the direction, assistance, and support to allow the person to live in the community, establish meaningful community associations, and make valued contributions to his/her community.

e. On-going consultation, community support, training, problem-solving, and technical assistance to ensure successful implementation of his/her person-centered plan.

f. Development and implementation of community support strategies that aid and strengthen the involvement of community members who assist the person to live in the community.

g. Through the Waiver, consumers of SWHHS will choose a variety of supports which will be provided within the SWHHS annual budget established by the Department of Human Services.

Section 3 – Participation Criteria/Responsibilities of the Involved Parties

a. **Consumer:** (Throughout the remainder of this document, "consumer" may also mean what is appropriate to each situation: parents/guardians of minor children, the legal representative for an adult with developmental disabilities, or an individual the consumer/his/her support team designates to assist in a particular area.) To receive a Home and Community Based Waiver slot the individual must:

- Be the financial responsibility of a county served by SWHHS;
- Be receiving case management services through the Adult Services Unit of SWHHS;
- Be eligible and receiving Medical Assistance;
- Be certified disabled (CADI, CAC, BI);
- Be screened, eligible for and choose to receive Waiver Services;
- Choose Consumer Directed Community Support as their service of choice;
- Work with the case manager to develop a Community Support Plan (CSP).

b. **County Agency**: Required functions (The cost of this service is not paid from the Individual's Annual Waiver Budget.) EW and AC costs are within the case mix cap.

- Screen and determine if individual is MA Eligible.
- Screen and assess to determine if the individual is eligible for waiver services including level of care requirements.
- Provide information regarding HCBS alternatives to make an informed choice.
- Provide CDCS consumers with resources and information to assist them in managing the service and accessing and developing the supports.

- Evaluate that the consumer's health and safety needs are expected to be met given the care plan, including provider training and standards.
- Evaluate if the plan is appropriate, including that the goods and services meet the service description and provider qualifications, rates appear to be appropriate, etc.
- Provide consumers with information about CDCS to assist in securing administrative assistance to implement the supports.
- Authorize resources for the purchase of CDCS in accordance with this policy.
- Approve Community Support Program (CSP) plans.
- Manage costs associated with CDCS within the county's unique allowable average.
- Maintain responsibility for the case management services including eligibility and review of individual needs, development of the Community Support Plan (CSP), and monitoring of service activity including expenditures.
- Assure the services do not duplicate any other source provided.
- Work with the consumer to assure that CDCS meets the consumer's health and safety needs and preferences and are directed at the desired personal outcomes.
- Verify that service providers have met the standards identified in the ISP and CSP plans.

c. **Flexible Case Management**: (Cost of the provision of this service is included in the consumer's CDCS budget.) It is not a required service for CDCS. These are services provided to the recipient that are above and beyond what is provided by the required Case Manager. Direct Support Functions include:

- Provide consumer with information about CDCS and provider options;
- Facilitate the development of a person centered community support plan;
- Monitor and assist with revisions to the CSP;
- Assist in recruiting, screening, hiring, training scheduling, monitoring and paying Workers;
- Facilitate community access and inclusion;
- Monitor the provision of services including such things as interviews and monitoring visits with the consumer and service providers;
- Provide staff training that is specific to the consumer's plan of care.

Section 4 – Consumer Process for Service Authorization

a. Case managers discuss CDCS as an option and provide written information about CDCS to consumers when screening.

b. If a consumer expresses interest in pursuing CDCS option once receiving waiver services, further education is offered regarding the waivers and SWHHS CDCS process.

c. The consumer is assigned an individual annual budget by DHS.

d. The consumer selects an agency contracting with SWHHS to provide Fiscal Support Entity.

e. With assistance from someone of the consumer's choice and input from the Fiscal Support Entity, the Health and Safety Plan, and the CSP and Expenditure Plan.

f. The Waiver Advisory Committee reviews the CSP, the Health and Safety Plan, and the CSP and Expenditure Plan according to established criteria and approves or disapproves the plans.

g. Based on the approved plans, a formal working agreement is established among the consumer, the Fiscal Service Entity, and the case manager.

h. The consumer's team monitors the consumer's services based on the method agreed upon by the team.

i. On an annual basis or as needed, the Consumer's Plan, Health and Safety Plan, and CSP and Expenditure Plan are reviewed, revised, or updated.

j. On an annual basis, the consumer completes and submits to the case manager a report of progress towards CDCS outcomes.

Section 5 – Resource Allocation

a. Individual annual budgets are developed by DHS for each consumer. The budgets will be determined by a formula created by DHS and based on the current screening document. The allocation must be manageable within the annual budget of SWHHS.

b. Each consumer must incorporate the costs for all services and supports, both formal and informal, within his/her annual budget allocation.

c. Each year a new budget will be set based on the previous year's budget. Funds for the budget will not be reduced in a given year if authorized funds from the previous year went unspent. Unspent funds cannot be carried over to the next year.

d. The following circumstances may result in a change in the annual budget:
- Moving from their home to an assisted living situation;
- Moving from placement to a home;
- SIGNIFICANT changes in health, behavior or supervision needs.

Section 6 – Consumer-Directed Support and Expenditure Plan

a. All consumers utilizing the CDCS service option must have an individualized Community Support Plan, a Health and Safety Plan, and a corresponding expenditure plan.

b. Plan Components
Consumers may seek assistance from whomever they choose to develop the CSP plan. All CSP plans must address the following areas that are specific to CDCS services:
- Components that contribute to community inclusion;
- Evidence that CDCS will lead to an inclusive life, build a support network, and result in outcomes specified by the consumer including natural supports;
- Specific training, experience and/or education standards required of the provider to meet the unique needs of the consumer;
- Assurance of the health and safety needs of the consumer;
- Assurance that there is no duplication of services;
- The process that will be utilized for monitoring the service.

c. Plan Approval Process
The Waiver Review Committee composed of the Adult Services supervisor and at least two other members of the LTC Unit will meet as needed to review completed CSP and Expenditure Plans.
- The consumer's case manager will submit the completed plan along with the completed Health and Safety Plan to the supervisor.
- In the presence of the case manager, the Waiver Review Committee will review the plan to assure that the plan for CDCS is within the service parameters and the following authorization criteria:
  - ❖ The plan has a reasonable expectation of addressing the identified outcomes and health and safety concerns.
  - ❖ The plan enables the consumer to lead an inclusive life and build a viable network of support.
  - ❖ Services in the plan are not duplicative of other services.
  - ❖ Supports are beneficial primarily to the person with the disability.

- ❖ Costs of implementing the plan represent those that are over and above the normal costs for caring for the person with the disability if he/she did not have a disability.
- ❖ Be the least costly alternative that reasonably meets the individual's identified needs.
- ❖ Costs for supports fall within a customary cost range for similar supports, goods, and/or services.
- ❖ Expenditures in the plan are defensible to the taxpayer and the funding source.

The Waiver Review Committee will complete the Consumer-Directed Support and Expenditure Plan Review form and return the form and plan to the case manager for revision or implementation.

d. Amending the Plan

The approved CSP plan is considered to be the plan in effect unless and until any proposed changes are submitted to the case manager and approved. The plan must be amended and re-approved when:

- Funds are moved from one category to another(e.g., from informal supports to goods);
- An item or service is added to the current CSP Plan;
- The annual budget amount changes (exception is the cost of living increases granted by the state); and
- An item or service costing more than $500 is substituted for a similar previously approved item or service.

Revision during the plan and budget year may be approved by the county social service supervisor.

Section 7 – Hiring and Purchasing

Four categories of services and supports may be covered under CDCS: All categories of service must comply with the CDCS waiver service description and provider standards.

a. Types of Services

- Personal Assistance
  Personal assistance includes a range of direct assistance provided in the consumer's home or community. Consumers determine the provider's qualifications. The assistance may be hands-on or cueing. The following are typically covered under this category:
  Assistance with activities of daily living and incidental activities of daily living.
  - Respite care
  - Homemaking
  - Extended transportation

- Treatment and Training
  Treatment includes a range of services that promote the consumer's ability to live in and participate in the community. Providers must meet the certification or licensing requirements in state law related to the service. The following are typically covered under the category:
  - Specialized health care
  - Extended therapy treatment
  - Facilitative services
  - Day services and programs
  - Training and education to paid of unpaid caregivers
  - Training and education to recipients to increase their ability to manage CDCS services

- Environmental Modifications and Provisions
  Environmental modifications and provisions include supports, services and goods provided to the recipient to maintain a physical environment that assists the person to live in and participate in the community or are required to maintain health and wellbeing. The following are typically covered under this category:
  - Assistive Technology;
  - Home and vehicle modifications;
  - Environmental supports (snow removal, lawn care, heavy cleaning);
  - Supplies and equipment;
  - Special diets;
  - Adaptive clothing.

  Costs exceeding $5,000.00 may be negotiated with the county of financial responsibility and provided outside of the consumer's individual budget. The county of financial responsibility may authorize additional funding for assistive

technology and home and vehicle modifications within the counties overall waiver allocation. This cost would not be included in the consumer's individual budget.

The elderly waiver amount is set by DHS and limited to that amount per waiver year.

- Self-Direction Support Activities
  Self-direction support activities include services, supports, and expenses incurred for administering or assisting the consumer or their representative in administering CDCS. The following are typically covered under this category:
  - Liability insurance and workers compensation;
  - Payroll expenses including FICA, FUTA, SUTA, and wages, processing fees;
  - Employer shares of benefits;
  - Assistance in securing and maintaining workers;
  - Development and implementation of community support plan (CSP);
  - Monitoring the provision of services

b. Provider Qualifications
Entities or individuals meeting the unique needs and preferences of the consumer with a disability as specified in his/her CSP may provide CDCS.

- Siblings: A brother and/or sister of a consumer may be hired providing the sibling:
  - Has a job description;
  - Has a work schedule;
  - Meets criteria through the Department of Labor;
  - Meets criteria for a criminal background check; and
  - Is at least 18 years of age

  If the sibling is also the legal representative for the consumer, the criteria outlined below must also be met.

- Legal Representative: Parents of adult children who are legal representatives of their adult child and other legal representatives of consumers may be paid through CDCS provided the following are addressed in the consumer's ISP or CSP Plan and approved by the Waiver Review Committee:
  - The consumer's preference for the legal representative as Support Provider;
  - The role of the legal representative as a paid provider and the specific duties that will be performed as identified in a job description;

- Clear differentiation of the duties performed through CDCS and those provided as a legal representative;
- Identification of conflict of interest, if any, and how it will be resolved;
- Assurance of the health, safety and welfare of the consumer;
- The plan for monitoring the support service; and
- Assurance of there being no duplication of services.

- Parents of Minor Children: Services and supports may be provided by legally responsible individuals including biological and adoptive parents of recipients under 18. For a recipient's spouse or parent of a minor recipient to be paid under CDCS, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:
  - Meet the definition of a service/support as outlined in the federal waiver plan and meet the criteria for allowable expenditure under the CDCS definition;
  - Be a service/support that is specified in the individual plan of care (Community Support Plan -CSP);
  - Be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the individual's community support plan (CSP);
  - Be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care attendant (PCA) services;
  - NOT be an activity that the family would ordinarily perform or is responsible to perform;
  - Be necessary to meet at least one identified dependency in activities of daily living as assessed using the Long Term Care Consultation Screening Document.

  The Screening Document will be used to provide a means to identify activities in which the recipient is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age.

In addition to the above:

- The family member providing the service must meet the qualifications or training standards necessary to perform the service or support which must be described in the individual's Community Support Plan (CSP);
- A parent/parents in combination or a spouse may not provide more than 40 hours of services in a seven day period. For parents, 40 hours is the total amount regardless of the number of children who receive services under CDCS;
- The family member must maintain and submit time sheets and other required documentation for hours paid;
- Married individuals must be offered a choice of providers. If they choose a spouse as their care provider it must be documented in the CSP;

- Monitoring Requirements
  In addition to the specified requirements for reporting and monitoring, when selecting CDCS as an option, these additional requirements will apply to consumer's electing to use legally responsible family members as paid service providers:
  - Monthly reviews by the fiscal agent of hours billed for family provided care and the total amounts billed for all goods and services during the month;
  - Planned work schedules must be available two weeks in advance and variations to the schedule must be noted and supplied to fiscal entity when billing;
  - At least quarterly reviews by the county on the expenditures and the health, safety and welfare status of the individual recipient;
  - Face-to-face visits with the recipient by the county on at least a semi-annual basis and more often if necessary or requested.

- Persons under State Guardianship/Conservatorship receiving CDCS:
  - The consumer's case manager must seek an alternative to state Guardianship/Conservatorship.
  - If no alternative can be found, a service coordinator must be identified. The service coordinator can be an agency or an individual who is paid or unpaid.
  - If paid, the person who is the service coordinator or the service coordinator's agency establishes the reimbursement rate which is included in the consumer's individualized budget.
  - The service coordinator manages the day-to-day details of the CSP Plan.

- Fiscal Support Entity:
  - Assumes the administrative, programmatic, financial and legal responsibility of the employees;
  - Will maintain all financial records related to the employees;
  - Will prepare state and federal withholding tax statements and send to appropriate state and federal offices

c. Resource Management Options

Consumers of the DD/RC waiver will have several options for allocation of resources to pay for necessary supports.

- County Payments to Vendors
  - Services licensed by the Minnesota Department of Human Services.
  - Services and other designated MR/RC waiver options may be paid for utilizing the usual county payment and state reimbursement systems.
  - Consumers must choose to direct all or part of their resources to this option. If a consumer chooses to hire services or supports from an individual who does not work for a licensed provider agency, a Fiscal Service Entity and/or Employer of Record must be used.

SWHHS reserves the right to direct a consumer's resources to the vendor payment option if other options for the consumer have proven unsuccessful or guidelines have not been met.

- Fiscal Support Entity
  - If a consumer wishes to receive services from individuals who are unlicensed, he/she must direct a portion of his/her annual budget to pay for the services of a Fiscal Intermediary agency which will allow reimbursement for services to occur.
  - The DD/RC waiver options of unlicensed personal support, unlicensed respite care, and specialist services must be purchased through a FSE/ER agency. Other services and supports such as caregiver training and education, consumer training and education, environmental modification, assistive technology, transportation, and Consumer Directed Community Supports may be purchased through this option as the consumer chooses.

SWHHS will contract with a provider who will provide Fiscal Intermediary and/or Employer of Record services. Consumers will need to establish a working agreement with the agency.

d. Expenditure Criteria:

Expenditures associated with the MR/RC waiver and the CDCS option and outlined in the consumer's CDS Plan must meet the following criteria:

- Are directly related to the needs of and have specific benefit to the individual with the disability;
- The health, welfare, and/or safety of the individual with the disability is dependent on the expenditure;
- Fall within a customary cost range for similar support, goods, and services;
- Cannot be covered by other sources (e.g., private insurance, MA, Social Security, etc.) or those sources have been exhausted;
- Do not tie up funds (e.g., Certificates of Deposit, treasury bill/notes, life insurance premiums, etc.);
- Represent costs over and above those associated with individuals of similar age without disabilities; and
- Are defensible to the taxpayer and the funding source.

Other expenditure parameters: Additional parameters for expenditures as related to specific CDCS and other waivered services are as follows:

- Transportation
  - Funds cannot be utilized to purchase vehicles or directly maintain vehicles. The CDS Plan may establish a transportation budget based on exclusive use of the vehicle by the individual with the disability or on behalf of that person. Budget guidelines for nonpublic, non- agency transportation are at the federal reimbursement rate per mile for a car and per mile for accessible vehicles. A mileage log must be kept as documentation of the expenditures. Funds cannot be utilized to pay for transportation that can be funded by another source (e.g., DT&H, MA, school).
- Services to minor children living at home with their families:
- SWHHS will review and authorize expenditures based on guidelines established in the "Funding Guidelines for Parents of Minor Children" (see attachment A-1).

Expenditure Denials: If there is a denial of a particular expenditure request by the Waiver Review Committee, the consumer may request a review of the expenditure by the Social Services Management Team. The decision of the committee will be final. The consumer may file a Social Service Appeal with the State Appeals Office when there is a reduction in service level or a termination of services.

Section 8 – Quality Assurance

a. Multiple methods for assuring the quality of planning and support delivery will be utilized on a variety of levels. Case managers will monitor services through visits with the consumer, written documentation from the provider on progress, and meetings with consumer and team members. The case manager will review the budget on a semi-annual basis. A quality assurance survey will be conducted annually.

b. Consumer Responsibilities

- Develop individualized support/service monitoring process as part of the CSP Plan.
- Develop comprehensive consumer health and safety plan.
- Communicate concerns regarding support/services to appropriate party(s).
- Complete "Individualized Outcome" report on at least an annual basis.
- Complete county quality assurance survey as requested.

c. County Responsibilities

- Review CSP Plan to ensure health and safety and adherence to other CDCS criteria.
- Review performance of formal providers, including fiscal agent agencies, through monitoring of contract compliance.
- Attend team meeting of individual consumers as requested in the ISP or at least annually.
- Monitor expenditures utilizing fiscal agent and checking account processes.
- Develop and implement a periodic survey of consumer satisfaction with CDCS. Implement an internal review of policies and procedures to ensure consistency in decision making and appropriate response to client needs.

Section 9 – Exiting the Program

a. A consumer may voluntarily terminate his/her participation in the CDCS option of the DD/RC waiver by notifying the county case manager. A transition time for service and funding changes will be needed and determined on a case-by-case basis.

b. Involuntary Exits are identified in the federally approved waiver service of Consumer Directed Community Supports. When immediate health and safety concerns, maltreatment of consumers, suspected fraud or misuse of funds, or a 4th occurrence requiring additional technical assistance and supports beyond reasonable efforts (terms are defined below) arises, consumers will be **immediately** returned to other waiver and/or state plan home care services. Consumers who make purchases or engage in

practices not allowed within CDCS will be returned to other waiver or state plan home care services.

Section 10 – Definitions

a. Additional Technical Assistance and Support
Additional Technical Assistance and Support means an identified need for county involvement over and above the standard training and materials it may be triggered by discoveries during the county or FSE monitoring efforts that the Community Support Plan is not being followed. This may include but is not limited to:

- Not spending enough for services needed to support health and safety without a reasonable explanation;
- Not receiving goods or services identified as critical for health and safety;
- Ongoing difficulty in arranging for services needed for health and safety;
- Not following the CSP;
- Notices requesting missing information from the fiscal entity. The FSE will need to copy the county case manager on any and all notices requesting missing required information such as invoices or timesheets or FSE notifications that requests to purchase services or materials are not included in the approved CSP.

b. Reasonable Efforts
'Reasonable efforts' is defined as three documented events of need for additional assistance and support during one plan year. This documentation* must include:

- Identification of the problem,
- Corrective action needed, and
- A timeline in which to accomplish the action.

These events are described as 'documented' so SWHHS may choose to offer support for less significant implementation concerns, without rising to this level of documentation. SWHHS will document the additional technical assistance and support. This action may occur up to three times. An event that would otherwise trigger a fourth notice is cause for Involuntary Exit from the CDCS service for the remainder of the CDCS year.

Upon identifying the need for a *CDCS Notice of Technical Assistance and Support*, SWHHS will contact the consumer n an effort to resolve the outstanding issue. The consumer will also be sent a copy of the Notice and a copy will be retained in the SWHHS file.

'Immediate Concern' is defined as:

- Any matter jeopardizing health and safety,
- Evidence of unreported fraud,
- Maltreatment of the consumer, or
- Unapproved expenditures.

In the case of 'immediate concerns', consumers will be returned to other waiver services and SWHHS will notify the consumer of appeal rights.

c. Reported vs. Unreported Fraud

The context of this section relates to the consumer or parties acting on behalf of the consumer in using the CSCD service and managing the Community Support Plan.

This provision distinguishes reported verses unreported fraud based on the consumer's vulnerability and need for assistance.

For example, someone may feel they need to sign a fraudulent timesheet, and wait until the next worker came on duty to report the matter in a timely fashion to their supervisor.

In the event the consumer is involuntarily exited from CDCS for any of the above reasons, the following will occur:

- Case manager will immediately begin planning and implementing consumer access to other waiver or state plan services.
- Notice is sent informing the consumer of the return to other waiver services and/or state plan home care services,
- Consumer reverts to other waiver or state plan services,
- Case manager reports health, safety or abuse concerns to appropriate agencies such as CEP or child protection,
- Case manager reports fraud to Surveillance and Integrity Review Division.

When such actions are taken, it is only the CDCS waiver service that is terminated not the waiver program itself. Person centered planning and informed choices remain priorities. The Medical Assistance fair hearing and Medical Assistance notice requirements apply. However, CDCS is **not** available to the consumer during an appeal when the Involuntary Exit, pending appeal, is unique to this service and differs from other waiver services that require services stay intact pending an appeal hearing.

Section 11 – Criteria for Allowable Expenditures

a. The purchase of goods and service must meet all of the following criteria:

- Must be required to meet the identified need and outcomes in the individual's community support plan and assure the health, safety, and welfare of the individual;
- Goods and services collectively provide a feasible alternative to an institution;
- Be the least costly alternative that reasonably meets the individual's identified needs;
- Be for the sole benefit of the individual.

If all the above criteria are met, goods and services are appropriate purchases when they are reasonably necessary to meet the following consumer outcomes:

- Maintain the ability of the individual to remain in the community;
- Enhance community inclusion and family involvement;
- Develop or maintain personal, social, physical, or work related skills;
- Decrease dependency on formal support services;
- Increase independence of the individual;
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

b. Allowable Expenditures

Consumer Directed community supports may include traditional good and services provided by the waiver as well as alternatives that support recipients. There are four general categories of services which may be billed:

- Personal assistance
- Treatment and training
- Environmental modifications and provisions
- Self-direction support activities

Additionally, the following goods and services may also be included in the individuals' budgets (as long as they meet the criteria and fit into the above categories):

- Goods and services that augment State plan services or provide alternatives to waiver or state plan services

The guidelines below represent an attempt to differentiate the fiscal responsibilities of parents for their minor children from the costs that are over and above what is normal due to caring for a child with a disability. Parental responsibility continues even with the acquisition of a waiver slot. The DD/RC waiver does not pay for everything the recipient needs.

Only those expenditures that fall into the "Allowable Expenditures" category can be considered for approval as expenditure under the DD/RC Waiver programs, when appropriate. In addition to these guidelines, approved expenditures must also meet the following criteria:

- Be related to a need, support, or service identified in an approved Individual Support or Service Plan.
- Support the recipient's health, safety, independence, and/or general wellbeing.
- Contribute to the prevention of out-of-home placement.

- Represent a cost-effective strategy for meeting the needs.
- Fall within a customary cost range for similar supports, goods, and/or services.
- Be defensible to the taxpayer and the funding source.
- Be of specific benefit to the recipient.

SOUTHWEST HEALTH AND HUMAN SERVICES
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Expense Categories

1. Rent/Mortgage	None
2. Utilities-Electric, Gas/Oil, Water	The difference in cost between average utility costs and documented utility costs that significantly exceed average and are directly attributable to the recipient's disability.
3. Appropriate clothing for all occasions	The difference between a regular weather item of clothing and an adapted item of clothing of the same type. Articles of clothing that are not normally purchased and which are necessary due to the recipient's disability. Cost for extra clothing due to aspect of the recipient's disability which leads to numerous clothing changes or unusual wear and tear.
4. Food	Difference in cost between special diet and a regular diet which follows USDA recommendations for a person of similar age. Excessive amount of a certain food, which is referred/needed by recipient and the amount of that food which would normally be purchased.
5. Mattress, box spring, bed frame, and bedding	Difference in cost between basic sleep needs and needed adaptations to a bed based on recipient's disability and as recommended by appropriate professional. Includes cost of bed linens needed or nighttime incontinence.
6. Child care cost for children 12 years of age and under	Day care cost for persons over 12 years of age. Additional cost for a child 12 years and under for necessary supports to maintain them in appropriate child care setting.

7. Transportation to day care, after school activities/community activities	Transportation costs for a support person to take recipient to an activity or program identified in the ISP and/or IPP. Modifications to vehicle which allow for safe transport of recipient and which are directly related to recipient's disability.
8. Baby-sitting/respite expenses for children 12 years of age or younger	Respite cost for children over 12 years old. Additional cost associated with utilizing a person with specific skills that are necessary to provide adequate care to the recipient. Additional cost associated with the need for more frequent respite due to recipient's disability. Additional cost associated with need to hire additional person to provide adequate supervision to recipient.
9. Fees/cost for recreational activities for any equipment normally required	Cost of activity that is ordered by recipient's physician that is directly due to recipient's disability. Cost of a support person necessary for recipient to participate in activity and cost of support person's fees. Special adaptive equipment needed for recipient to participate in an activity.
10. Cost of animals/pets and supplies and food to care for pets regardless of therapeutic use	None
11. Cost of therapies that have not yet been proven to be medically effective in treatment of the individual's disability	None

12. Toys, games, videocassettes, computer program, games, or other equipment	Specialized play equipment recommended in writing by an appropriate professional that must be purchased through an equipment catalog or store specializing in adaptive play equipment. Additional cost of replacing toys or other play equipment that receives more than normal wear and tear; specifically due to the disability of the recipient.
13. Other items which will be a benefit to the entire family	Items which are of "documented" benefit to the recipient due to his/her disability and which are recommended in writing by an appropriate professional with knowledge of the disability.
14. Normal upkeep and maintenance of the home	Modifications to home that are of specific benefit to the recipient and directly related to recipient's disability.
15. Age appropriate supervision to assure health and safety of recipient	Cost of supervision strategies above and beyond those required for non-disabled children of the same age.

Other unallowable expenditures:

- Services provided to people living in licensed foster care settings, setting licensed by DHS or MDH, or registered as housing with services establishment;
- Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services;
- Services, goods or supports provided to or benefiting persons other than the individuals;
- Any fees incurred by the individual such as MHCP fees and co-pays, attorney costs, or costs related to advocate agencies, with the exception of services provided as flexible case management;

- Insurance - except for insurance costs related to employee coverage;
- Room and board and personal items that are not related to the disability
- Home modifications that add any square footage;
- Home modifications for a residence other than the primary residence of the recipient or, in the event of a minor with parents not living together, the primary residences of the parents;
- Expenses for travel, lodging, or meals related to training the individual or his/her representative or paid or unpaid caregivers;
- Services provided to or by individuals, representatives, providers or caregivers that have at any time been assigned to the Primary Care Utilization and Review Program;
- Experimental treatments;
- Membership dues or costs;
- Vacation expenses other than the cost of direct services;
- Vehicle maintenance that does not include maintenance to; modifications related to the disability;
- Tickets and related costs to attend sporting or other recreational events'
- Pets and their related costs;
- Costs related to internet access.

SOUTHWEST HEALTH AND HUMAN SERVICES
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Attachment A

Southwest Health and Human Services
Consumer Directed Community Supports
Process

1. Receive A Waiver
2. Receive Information about CDCS
3. Make an Informed Choice of Services
4. DD/RC or LTC Screening
5. Participate in Training
6. Receive Technical Assistance
7. Receive the individual budget amount
8. Prepare a Community Support Plan
9. Plan reviewed by Waiver Advisory Group
10. Meet with Fiscal Support Entity
11. Formalize Working Agreement
12. Services Authorized
13. Right to Appeal Details Given
14. On-going Monitoring and Evaluation

SOUTHWEST HEALTH AND HUMAN SERVICES
SOCIAL SERVICE POLICY NUMBER 32

EFFECTIVE DATE: 07/17/13
REVISION DATE:
AUTHORITY: Southwest Health and Human Services – Human Services Board
MN Statute 256.476

--- CONSUMER SUPPORT GRANT (CSG) ---
POLICIES AND PROCEDURES

Section 1 – Purpose

a. The Southwest Health and Human Services (SWHHS) Consumer Support Grant (CSG) provides monthly cash grants to children and adults with disabilities living at home. CSG is an alternative for individuals and families who are eligible for the state plan MA Home Care programs of: Personal Care Attendant (PCA) Services, Home Health Aide (HHA) Services, and/or Private Duty Nursing (PDN). The program is designed to:

- Provide consumers more control, flexibility, and responsibility over their supports;
- Promote local program management and decision making;
- Encourage use of informal and typical community supports;
- Foster consumer independence and access to culturally appropriate.

Section 2 – Authority

a. MN Statutes, Section 256.476 provides the legislative authority for the Consumer Support Grant.

Section 3 – Eligibility

a. A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

- The person is eligible for and has been approved to receive PCA, HHA and/or PDN services under Medical Assistance (MA), as determined by MN Statute 256B.0625, .0651, .0655.
- The person is able to direct and purchase his/her own care and supports, or if the person is unable to direct his/her own care, a family member, legal representative or other authorized representative is available and willing to purchase arrange, and direct care on the person's behalf.
- The person has functional limitations, which require ongoing supports to live in the community, and is at risk of or would continue out-of-home placement without such supports.
- The person will live in a natural home setting. For the purposes of this program, "home" is defined as the person's own home or the home of the person's family member and is not licensed by MDHS or MN Dept. of Health.

- Between the ages of 0 and 65.
- The person is eligible to receive home care services from the PCA, HHA, and/or PDN Medical Assistance Home Care programs. Note: Plans for people that qualify under Private Duty Nursing require the Budget/Service Agreement plan be reviewed by the Department of Human Services (DHS), Disability Services Division (DSD).

Persons may not concurrently receive a Consumer Support Grant if they are:

- Receiving Home and Community-Based services under any waiver, (MR/RC, CAC, CADI, TBI, EW, AC) United States Code 7, title 42, section 1396 (c);
- Receiving personal care attendant service, private duty nursing, or home health aide service under MN.Stat.256B.0625;
- Alternative care services under MN.Stat.256B.0913;
- Residing in an institutional or congregate care setting;
- Persons who receive medical coverage through any of the State's managed care programs, i.e., Prepaid Medical Assistance (PMAP), Minnesota Senior Health Options (MSHO), or Minnesota Disability Option (MNDO) may not receive a consumer support grant because of a possible overlap in coverage;
- Persons who are presently receiving the Family Support grant (FSG), may also be eligible for the CSG. A person may not apply for the FSG if utilizing the CSG.

Section 4 – Program Description

a. The Consumer Support Grant (CSG) replaces services the consumer is eligible for or currently receiving through the Personal Care Attendant (PCA), HHA and/or PDN programs. Support grants will be provided to the person through a monthly payment in the form of a check or direct county payment to vendor. Support grants are to be used to pay for those additional expenses related to the support of the person with functional limitations. Each service and item purchased with a support grant must meet all the criteria outlined in the CSG Consumer Budget/Service Agreement. Examples of reimbursable expenses include respite care, modifications of home and vehicle to increase accessibility or safety, adaptive aids, special equipment, caregiver training, educational and chore services. Refer to the CSG Expense Categories and Expense Definitions for further clarification.

b. The program is funded entirely by the State of Minnesota with no Federal Medical Assistance dollars involved. DHS establishes monthly grant amounts by using the home-care rating from a current personal care assessment. (Persons transferring from a waiver must obtain a MA Health Status (home care/PCA and/or PDN) assessment rating, terminate their waivered services, and use their home care rating as the basis for their monthly CSG grant.) All other sources of payment should be exhausted.

c. SWHHS retains a 5% fee from the Consumer Support Grant for administrative costs.

Section 5 – Consumer Responsibilities

a. Initial Application Process
- Obtain Medical Assistance eligibility.
- Complete MA Health Status (home care/PCA and/or PDN) assessment with SWHHS Public Health Nurse.
- Complete CSG Budget/Service Agreement Plan with assistance from Case Manager as needed.
- Review and sign the CSG Statement of Informed Consent and CSG Release from Liability.
- Complete CSG County Approval of Payment to Parent of Minor or Spouse to Provide PCA Services, CSG Designation of Authorized Representative, plan for meeting State and Federal Tax & Labor Law Responsibilities, Private Duty Nursing Consumer Agreement (if applicable).
- Notify current home care agency to terminate service agreement in the month prior to the CSG start date.
- Secure a fiscal intermediary.

b. Ongoing
- Maintain Medical Assistance (MA) eligibility.
- Maintain a record of all grant expenditures.
- Keep receipts for all grant expenditures.
- Participate in a minimum of an annual CSG review with case manager after first year.
- It is each consumer's/legal representative's responsibility to inform their case manager of any issue which might affect their eligibility and participation in the CSG program.
- Consumers in the CSG program will continue to receive county case management services, if they have a Case Manager. However, by participating in the CSG program, consumers or their authorized representative are assuming primary responsibility for the arrangement and payment of their PCA, HHA, and/or PDN services.

Section 6 - Use of an Authorized Representative

a. If the county determines that a consumer is unable to direct his/her own care or manage his/her own supports, an authorized representative must be designated before the CSG grant can be issued. The authorized representative must be chosen by the consumer or the consumer's legal representative. If the consumer refuses to cooperate in the authorization of a representative, the support grant will not be approved.

b. The responsibilities of the authorized representative must be documented and signed by the consumer, the legal guardian and the authorized representative. A copy will be maintained in the case file. Responsibilities include:
- Purchase of supports
- Completion of forms
- Provide verifications
- Appeal county decisions
- Manage consumer benefits
- Exercise same rights and responsibilities as consumers

c. Authorized representatives must meet all of the following criteria:
- Be at least 18 years of age
- Be authorized in writing to act on behalf of consumer
- Have sufficient knowledge of consumer's circumstances to provide information necessary to the administration of the grant in a manner that guarantees the health and safety of the consumer.

d. The following individuals may not act as the authorized representative for a consumer:
- Members of the County Board
- County Workers
- Special investigative staff

e. Annual Renewals
- Authorized Representative and Consumer to complete and sign the CSG Annual Budget/Service Agreement Plan.
- Return any unused CSG funds to SWHHS.
- Review and sign the CSG Participation Agreement as well as the CSG Release from Liability.
- Complete CSG County Approval of Payment of Parent of Minor or spouse to provide PCA Services, CSG Designation of Authorized Representative, Private Duty Nursing Consumer Agreement (if any are applicable), Informed Consent.

Section 7 - Expenditure Guidelines

a. All expenditures of CSG funds must be in accordance with conditions outlined in the Human Services CSG Expense Categories, and outlined in the Budget/Service Agreement.

b. MN Statute 256.476 requires each service and item purchased with the support grant must:
- Be over and above the normal cost of caring for the person if the person did not have functional limitations;

- Be directly attributable to the person's functional limitations;
- Enable the person or the person's family to delay or prevent out-of-home placement of the person;
- Be consistent with the needs identified in the CSG Support & Expenditure Plan, when applicable.
- Have a reasonable expectation of addressing identified outcomes and health and safety concerns and the health, welfare and/or safety of the consumer is dependent on the expenditures.
- Not be duplicative of other services, including county funded services such as respite.
- Fall within a customary range for similar supports, goods, or services and represent a cost-effective strategy for meeting needs, and
- Be defensible to the taxpayer and to the funding source.
- Be those for which there are no other public or private funds available to the person or person's family. Fees assessed to the person or the person's family for Health and Human Services are not reimbursable through the grant.

c. Consumers must have an agreement with a Fiscal Intermediary and/or Employer of Record services to assure adherence to federal and state laws governing employment practices. The county may grant a waiver of this requirement upon a written request and a satisfactory plan for compliance with federal and state laws from the consumer or his/her authorized representative.

d. Payment through the CSG of a parent of a minor child or spouse to provide PCA services will be considered an allowable expenditure if one of the following criteria is met:
   - Parent or spouse resigned from full-time/part-time employment to provide care to the child.
   - Parent or spouse changed from full-time to part-time employment to care for child and compensation was reduced as a result.
   - Parent or spouse took leave of absence without pay to care for child.
   - Parent or spouse is needed to provide care because of labor conditions, special language considerations, or intermittent hours of care.

e. Payment through CSG of the legal guardian or spouse of a consumer for the provision of direct support can be considered an allowable expenditure. In the case of a parent of a minor, spouse or legal guardian of a consumer as the paid employee, that individual may be paid at a rate no more than the current rate paid by DHS for PCA agency services and not to exceed 40 hours a week. If both parents are paid care givers, the weekly hours combined cannot exceed 40 hours.

f. The initial CSG Budget/Service Agreement, and the Annual CSG Budget/Service Agreement must be approved by the County Case Manager/County Representative and Unit Supervisor prior to utilization. After approval, changes to the plan that comply with

CSG approved expenditures and are within the consumer's budget may be authorized at the discretion of the Case Manager/County Representative.

g. A denial by the county regarding payment of Consumer Support Grant funds may be appealed through the Minnesota Department of Human Services in accordance with State law.

Section 8 - Misuse of Grant Funds

a. If there is a suspicion or evidence of misuse of grant funds, i.e., spending funds outside of an approved plan without prior approval or refusing to return unexpended funds, the county will proceed as follows:

- The county, through the case manager will collect all pertinent documentation including receipts, logs, Fiscal Intermediary/ Employer of Record reports, etc. for the past grant year for review.
- The review will be conducted by Human Services.
- If misuse of funds has occurred, Human Services will send a letter to the consumer outlining the findings of the review, amount of funds that must be returned to the county from the consumer's own resources and the name and telephone number of the county collection officer who can assist the consumer in working out a plan for payment.
- A copy of the letter to the consumer will be given to the collections officer who will then contact the consumer to work out a payment plan. Consumers will be given 90 days to pay back what is owed. Exceptions to this timeline may be made if payment would cause undue hardship to the consumer.
- If the consumer fails or refuses to repay misused grant funds, the county collections department may take legal or administrative action to obtain repayment.
- Consequences for consumers who have misused grant funds or who have neglected or refused to repay misused funds may be one or more of the following depending on the severity of the misuse:
    - Training in the area of plan development, fiscal management, consumer responsibilities, etc.
    - Termination of the CSG grant.
    - Return to traditional MA PCA, HHA, and/or PDN services.

Section 9 - Grant Award Period

a. Community Support Grants are provided on a monthly basis with a 12 month annual year. The annual year begins on the date of the initial PCA assessment, the PCA Assessment is then conducted annually for re-determination of grant eligibility. Before a grant begins, a consumer must meet county determination of eligibility.

Initial CSG recipients will need to have a PCA Assessment, an approved Budget/Service Agreement, completed applicable consent forms, and have secured a Fiscal Intermediary by the 15th of the month in order for the grant to begin in the following month. Unused funds will be returned to the county by the Fiscal Intermediary. If funds are misused or unaccounted for, recovery action will be taken by SWHHS and the State of Minnesota.

Section 10 - Reporting of Grant Expenditures

a. Each consumer or his/her authorized representative must keep receipts and a record of all grant expenditures. Human Services requires that grant recipients utilize a fiscal intermediary or employer of record. At the time of the annual re-determination of eligibility and before the grant can be renewed, the consumer must have completed an approved Budget/Service Agreement plan, and completed applicable consent forms.

Section 11 – Case Management/County Representative Responsibilities

a. The Case Manager/County Representative will monitor the grant at the very least on an annual basis and be available for consultation or problem solving as requested.

b. Case Manager/County Representative and Unit Supervisor review initial and annual CSG Budget/Service Agreements, ensuring the plan is in accordance to Human Services CSG policy and procedures and reflects the health and safety considerations of the consumer. Further requests to utilize funds or transfer funds within the allowed expenditure categories may be approved at the discretion of the Case Manager.

c. The Case Manager/County Representative will review the CSG Statement of Informed Consent with the Consumer, Authorized Representative and Legal Guardian. Families will be informed that CSG funds paid as wages to a caregiver, are considered the caregivers earned income and are therefore subject to income taxes. Additional income may effect financial programs such as Medical Assistance (MA), Social Security(SS), Supplemental Security Income(SSI), Minnesota Family Investment Program (MFIP), and the MA program: Tax Equity and Fiscal Responsibility Act (TEFRA).

d. The Fiscal Intermediary or Employer of Record will discuss and inform the consumer/legal representative of their rights and responsibilities in the employer/employee relationship.

Section 12 – Exiting the Program

a. Temporary Out-of-Home Placement

- For consumers who enter temporary out-of-home placement for 60 consecutive days or less, the grant will be prorated. For consumers who enter temporary out-of-home placement over 60 days, the support grant must be terminated. Upon return to the home, the consumer may reapply for the grant with dollar amounts based on the DHS allocation grid (please see attached).

b. Move to Another County

- The Consumer Support Grant is not an excluded time service. When a CSG recipient moves to another county in Minnesota which is participating in the CSG, and at the point where that county assumes financial responsibility, the designated county representative will transfer the case to the new county and notify the Minnesota Department of Human Services. The county representative in the new county will be responsible for setting up payments to the consumer. If the new county is not a CSG participant, the consumer's CSG grant will be terminated.

c. Termination of Grant

- The Consumer Support Grant will be terminated when:
  - The consumer moves out of state or to a Minnesota county not participating in CSG;
  - The consumer enters a nursing home, licensed foster care facility, or other institutional setting for more than 60 consecutive days;
  - The consumer's ability to direct his/her own care diminishes to a point where they can no longer do so and there is no responsible person available to do it for them;
  - The consumer needs an authorized representative to manage their services and there is no one available to perform that function;
  - The consumer refuses services;
  - The consumer no longer meets all the eligibility criteria for the CSG program;
  - The consumer or his/her representative misuses or refuses to use the Consumer Support Grant to pay for the services identified in the Budget/Service Agreement.
  - The consumer or his/her representative refuse to provide specific documentation of how the CSG funds were spent after requested to do so by the County representative;
  - The consumer has two times within a thirty day period refused to schedule an appointment for reassessment or has failed to keep three scheduled appointments for assessment or reassessment within a thirty consecutive day period.
  - The consumer chooses to return to his/her former service program;
  - The consumer's health and safety needs are being jeopardized.
  - The consumer dies.

d. Appeals

- Consumers have the right to appeal a denial, suspension, or termination of services under this program pursuant to Minnesota Statute 256.045, subdivision 3.

Section 13 – Expense Categories

a. Formal/Informal Supports

- **Adult Daycare** - Adult daycare is available to persons who are 18 years of age or older, and encompasses both health and social services which are needed to ensure their optimal functioning.

- **Chore Services** - Chore services are needed to maintain the home in a clean, sanitary and safe environment. This includes heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home, and shoveling snow to provide access and egress.

- **Companion Services** - Companion services consist of non-medical care, supervision and socialization provided to an adult with functional limitations. A companion may assist with such tasks as meal preparation, laundry and shopping, but does not perform these activities as discrete services. A companion may also perform light housekeeping tasks which are incidental to the care and supervision of the consumer and may accompany the individual into the community. Companion services are provided in accordance with a therapeutic goal in the individual service plan; they are not merely diversionary in nature.

- **Homemaker Services** - Homemaker services include meal preparation, routine household care, shopping and errands, assisting with daily activities, arranging transportation, providing emotional support and social stimulation, and monitoring safety and well being.

- **Independent Living Skills (ILS)** - ILS services are directed at the development and maintenance of community living skills and community integration. Services may include supervision, training, or assistance to the consumer with self-care, communication skills and socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living and mobility.

- **Personal Care** - Personal care services include assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may also

include meal preparation and such housekeeping chores as bed making, dusting and vacuuming, which are essential to the health and welfare of the consumer.

- **Respite Services -** Care provided to give temporary relief or rest to the CSG recipient's care giver(s). Respite services are to be provided in a natural home setting, and cannot be used in a licensed facility.

b. Services

- **Care Giver Training and Education -** Caregiver training and education is a service provided to an informal caregiver of a consumer which enables the caregiver to deliver care in the home setting with high levels of quality. Training may include transfer and lifting skills, nutrition, personal/physical cares, home security, behavioral management, long-term care decision making, care coordination and family dynamics.

  Training and education of caregivers is provided by health care professionals, such as public health nurses, registered nurses and licensed practical nurses. Vocational and technical schools offering courses such as home health aide and certified nursing assistant training may also provide training and education.

- **Consumer Support Grant Expenses -** Costs that you incur administering your CSG dollars, such as liability insurance, unemployment compensation, fees to attend training about managing your care and/or your CSG, and fees paid to a fiscal agent to perform payroll services.

- **Daycare -** After school or weekend daycare expenses for recipients who, because of their disabilities, are not able to remain at home unsupervised, as would a similar aged person without disabilities, are allowed.

- **Educational -** This category includes the cost of educational programs and services that are not available through the recipient's local education agency, or are necessary in addition to those provided by other sources. Items which parents would either be expected to provide, or have the option of providing if their child did not have a functional limitation are not allowable.

- **Family Counseling and Training -** Family counseling and training include services for the consumer as well as the family with whom he/she lives or who routinely provide care. Family is defined to be the persons who live with or provide care to a consumer and may include spouse, children, friends, relatives, foster family, or in-laws.

Training is for the purpose of increasing the consumer's or family member's capabilities to maintain and care for the consumer in the community. It includes use of equipment and treatment regimes as specified in the care plan. Periodic training updates may be necessary to safely maintain the consumer in the community. Counseling may include helping the consumer and/or his or her family members in crisis, coping strategies, stress reduction, etc.

- **Delivered Meals -** A home delivered meal is an appropriate, nutritionally balanced meal served in the home of a consumer support grant recipient. Home delivered meals will be provided to consumers who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet the consumer's individual requirements. The CSG will not supplant other funding sources.

- **Cellular Phone –** Cell phones may be approved for emergency use in the community as it relates to the disability. Purchase of a cell phone must not exceed $100 and the ongoing service may not exceed $20 per household per month. Any rates above this require special documentation and approval form the CSG Team.

- **Medical -** Allowable medical expenses are those which are not reimbursable through private insurance, Medical Assistance, or other private social services funds. Bills that were incurred prior to MA eligibility and/or expenses, which are in excess of that covered by the consumer's private insurance when they have been determined to be ineligible for MA, are allowed.

- **Medication -** Medication expenses include the cost for prescription and non-prescription substances which are needed due to the recipient's functional limitation, and are not reimbursable through other funding sources, such as MA or private insurance.

- **Nutrition Services -** Nutrition counseling are one or more individual sessions in which a registered dietitian, or registered nurse provides advice or guidance in solving a client's diet related health problems. Examples include planning diabetic meal patterns to meet client needs, therapeutic diet suggestions for clients who are chronically underweight, have had severe weight loss, have difficulty chewing or swallowing, weight reduction diets, etc.

  Nutrition education is an individual or group event, which provides formal or informal opportunities for individuals to acquire knowledge, experience and skills about foods and nutrition. Examples of class topics are: wise food choices

at grocery shopping, food selection and preparation, methods for therapeutic diets, menu planning foods safety storage tips, cooking for one or two, tips for eating well on a limited budget.

- **Special Diet -** Unusually high food and supplement costs due to special diets prescribed by a physician in an amount beyond the USDA recommendations for a person without a disability of similar age. The need for dietary supplements must be directly related to the recipient's disability and must not be reimbursable through other funding sources such as MA, WIC, food stamps, etc. A doctor's order for special diets will be required.

- **Transportation -** Expenses for transportation that is incurred, as a result of the recipient's functional limitations should be reasonable and based on the county practice. Expenses must not be reimbursable through other funding sources (e.g., transporting recipients to medical appointments and hospitals are reimbursable through MA and therefore would not be allowed). Transportation costs to community environments and school-related activities which a parent would be expected to provide if the recipient did not have a functional limitation are not allowed (e.g. transportation to and from shopping centers, recreation centers, daycare provider, after school activities).

c. Goods

- **Modification and Adaptations of Home** - Home modifications include minor physical adaptations to the home which are necessary to insure the health, welfare and safety of the individual, or which enable the consumer to function with greater independence in the home.

  Such adaptations may include the installation of ramps and grab-bars, widening of doorways, installation of visual and/or tactile signaling devices (such as fire alarms, baby cry signalers and doorbells), modification of bathroom facilities, etc. Adaptations or improvements to the home (carpeting, roof repair, central air conditioning, etc.), which are not of direct medical or remedial benefit to the consumer are excluded.

  Modifications and adaptations also include minor modifications to vehicles, which will allow the individual to function with greater independence in the community. Such modifications may include wheelchair lifts, adapted seating, door widening, door handle replacements, wheelchair securing devices, etc. Examples of adaptive equipment include adaptive furniture and utensils. Vehicle & home modifications must have a signed Vehicle & Home Modification Agreement Form by the Consumer/Responsible Party on file.

- **Supplies and Equipment** - Supplies and equipment includes durable and non-durable medical supplies and equipment, which are necessary due to the consumer's functional limitation, but not covered by MA. Supplies and equipment may also include devices, controls, or appliances, which enable the consumer to increase his/her ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which he or she lives, and includes ancillary supplies necessary for proper functioning of items.

- **Clothing** - This category includes the cost for extra clothing and bed linens required for a person with nighttime incontinence, or for a person whose garments wear out quickly due to movement patterns resulting from a disability. It also includes specially designed clothing for recipients with physical disabilities, and articles for which other funding is not available (e.g., orthopedic shoes, helmets for head protection during seizures).

- **Equipment** - Equipment required by a recipient with functional limitations for which no other funding is available. Examples of these types of expenses include bath chairs, adapted toilet seats, or specially adapted car seats.

Occasionally, there are items that may be needed because of one's functional limitations, that allow them to live independently in their own home, but that do not fall into any of the preceding categories. To be an allowable expenditure, services and supports needed must be:

- Over and above the normal cost of caring for a person if they did not have functional limitations;
- Directly attributable to the person's functional limitation;
- Enable a person to delay or prevent out-of-home placement.

Section 14 – Vocabulary

a. **Authorized Representative** - A responsible individual designated by the grant participant or their legal representative to act on their behalf

b. **Community Support and Expenditure Plan** - A document in which the participant indicates how the grant monies will be utilized, including specific goals, staffing pattern, amount staff will be paid, list & costs of support services, health & safety plan, current fiscal agent and signatures.

c. **Consumer Directed** - Programs in which the recipient or their legal representative, determine goals and select services/goods to meet their needs; manage the services; monitor for health/safety, as well as provide financial management.

d. **Consumer Support Grants** - Grants for participants with functional limitations who need supports and services in order to remain at home. Serves as an alternative to some home care services available through 'straight' MA. This cash grant program was established to promote increased consumer independence along with accountability to select goods, services and supports. The use of informal and community supports is encouraged, as well as access to culturally appropriate care.

e. **Customary** & **Reasonable Rates** - Market based fees that fall within a common or usual range for similar services/supports.

f. **Department of Human Services (DHS)** - The State of Minnesota's department that provides health care, economic assistance, and other services for persons who do not have the resources to meet their basic needs.

g. **Family Support Grant (FSG)** - A cash grant program to families that offsets the higher-than average expenses that are directly related to their child's disabilities **in** maintaining them at home. Once a recipient enrolls on CSG, they are no longer eligible for FSG; ***unless*** they had FSG prior to enrolling on CSG, then they may keep both.

h. **Fiscal Support Entity** - An agency you hire to facilitate the payment of CSG services and offer a range of services/supports. The consumer determines how much assistance they will contract for with the fiscal agent, with a wide or minimal range of services available, such as managing taxes and payroll.

i. **Flexible Case Manager (FCM)** - A professional you may hire and pay within your current grant amount to assist with a variety of grant related tasks, including writing your plan, hiring staff, assisting with staff schedules and creating job descriptions.

j. **Home Care Rating** - A one or two letter code indicating the level of dependencies as determined by public health nurse during a M.A. home care assessment.

k. **Institutional Level of Care** - Care and services associated with a particular facility type, such as nursing facility, hospital, or intermediate care facility for persons with mental retardation or related conditions (ICF/MR).

l. **Medical Assistance (MA)** - A state and federal program administered by the counties that provides health care coverage for certain eligible groups of people.

m. **MA Health Status Assessment** - An assessment that determines your need for assistance. The assessment reviews the tasks and assistance that you need in your home.

n. **MA Home Care** - Medical and health-related services and assistance provided to people in their home. It can be used to provide short-term care for people moving from a

hospital or nursing home back to their home, or it can be used to provide continuing care to people with ongoing needs.

o. **MA Home Care Service Authorization** - A statement from DHS that tells you what services you are approved for, the amount of services you are approved for, and who is providing those services.

p. **Natural Home Setting** - For the purposes of the CSG, "home" is defined as the person's own home (this is the person's own home, even though they might not own it). These "homes" are not licensed by the Department of Health and Human Services or are not registered housing services.

q. **Parent Case Management** - A county program that allows parents to take over their current case manager's role in arranging for goods and services to meet the needs of their child with developmental disabilities.

r. **Person Master Index (PMI)** - An identification number assigned to each MA recipient by the State of MN, which is utilized in the state's computer system (MACS) and requested throughout various form completion. The PMI number is eight digits long and always starts with a zero.

s. **Prepaid Medical Assistance Program (PMAP)** - Health plan contracted with DHS to provide health care services to its recipients.

t. **Primary Caregiver** - A person who most frequently attends to the needs of individuals who have functional limitations.

u. **Primary Contact** - County staff who will approve and monitor your plan. You may call them directly for questions and information.

v. **State Set Allocation** - A dollar amount determined by DHS that is distributed to the county agencies to serve people in the community. The dollar amount is based on the average resource needs of persons with similar functional characteristics.

w. **Tax Equity and Fiscal Responsibility Act (TEFRA)** - A program that provides MA eligibility to some children with disabilities living with their families, who ordinarily wouldn't be eligible for MA because of parental income.

SOUTHWEST HEALTH AND HUMAN SERVICES
SOCIAL SERVICE POLICY NUMBER 33

EFFECTIVE DATE: 07/17/13
REVISION DATE:
AUTHORITY: Southwest Health and Human Services – Human Services Board
MN Statute *256B.49*

--- CAC, CADI, AND BI WAIVERED SERVICES ---
RESOURCE MANAGEMENT POLICY
(Aggregate Financial Management, Prioritize Consumers to Receive Services and Establish a CAC, CADI, and BI Wait List)

Section 1 – Purpose

a. Southwest Health and Human Services manages the CAC, CADI, and BI waiver according to MN Statute, Section 256B.49 and the Disability Services Manual.

b. This policy defines the aggregate financial management, the process of selecting consumers who will receive CAC, CADI or BI Waivered Services, and the establishment of a Wait List. The process to resolve any conflicts about resource utilizations shall be the appeals process which all consumers are notified of at time of the initial LTCC, annually at reassessment and more often if required.

c. Southwest Health and Human Services may not be able to serve all eligible persons requesting CADI or BI-NF Waivered services. Beginning in July 1, 2003, DHS assigned a limited number of CADI and BI-NF diversion allocations each year for new waiver recipients for whom the agency is financially responsible. The diversion allocations can be used interchangeably for CAC, CADI and BI-NF. Southwest Health and Human Services will manage and award the allocations for all 6 counties served by our agency. After referral and LTCC (Long Term Care Consultation) is complete, case managers in consultation with supervisor will consider the State Plan and the ability of that plan to serve the consumers needs. If the State Plan meets the consumer's needs, the consumer is not eligible for waivered services. Southwest Health and Human Services will assist consumers to receive supports in the least restrictive and most integrated community alternatives possible.

Section 2 – Agency Aggregate Financial Management

a. Southwest Health and Human Services is given a yearly waiver budget based on a calculation that utilizes current recipients' authorized services, along with additional flexible funds. The amounts for CAC, CADI, and BI are combined into one budget for all 6 participating counties. When a new recipient is opened to a new waiver slot, a

resource amount is added to the agency's waiver budget. This amount is determined from the LTCC and a DHS statistical-based formula. The resource amount is not an individual limit or an entitlement amount for the recipient.

Based on the assessed needs of any new person added to one of the waivers, the agency will determine an amount of funding that is indicated by the person's needs that assures the person's health and safety, complies with the agencies' procedures and criteria for allocation of waiver resources and is within the agencies' waiver budget. Annual reviews and reauthorization of services will be completed. This review and reassessment is intended to verify continued eligibility for services and to determine if current services are sufficiently meeting the needs identified in the service plan.

b. Southwest Health and Human Services will manage the budgets to assure that total authorizations do not exceed the total allowable dollars within the aggregate year (fiscal year July 1 to June 30). Southwest Health and Human Services may review allowable funds that have not yet been authorized, in the last quarter of the fiscal year to consider the use towards client specific needs for one time authorizations such as modifications and assistive technology. Decisions will be based on the latest update of the Waiver Tracking System. Current eligible recipients cannot be terminated from the waiver for the sole purpose of the agency's management of the waiver budget allocation.

c. Changes in Resource Amount
- When an individual is reassessed and their needs change, their resource amount will not change with the exception of the individual's need changes from nursing facility level of care to hospital level of care.

d. Reuse Allocations
- The funds available when a recipient exits that waiver may be used to serve an additional waiver recipient and/or for increased needs of the current recipients if the increase is within the agency's budget. Southwest Health and Human Services is limited to servicing one new waiver recipient per each recipient that exits a waiver due to 2003 legislation to limit the growth of the CADI and BI allocations.

e. Change of Agency of Financial Responsibility
- When a waiver recipient's agency of financial responsibility changes, the waiver allocation and authorized amount will automatically transfer to the new Agency of Financial Responsibility (CFR). At the time of the transfer, the current CFR must close out the service agreement and the new CFR will open a service agreement. The waiver management system will use the service agreement to determine the CFR. Southwest Health and Human Services does not have the

capacity to provide service coordination to persons other than those that are the responsibility of Southwest Health and Human Services. The agency will continue to provide service coordination to consumers who live outside the three counties for whom we remain financially responsible.

Section 3 – Agency Management of Waiver Allocations

a. The case manager who completes the LTCC will meet with the CAC, CADI, and BI supervisor to discuss eligibility. If the State Plan cannot meet the person's needs, and they are eligible for waivered services, exploration of waiver availability will begin. Case manager will request the waiver for their consumer from the supervisor using form SS#273 "Request for Waiver Slot."

b. All counties in our joint powers agency will have equal access to all slots and dollars available. If funds need to be restricted with all things being equal the requests will be honored in the order they are received. Slots can be moved between the counties within our agency with State assistance. This assures access to the waiver in all agency counties. Priority consumers with the highest health risk will be approved first. Once the waiver request is simulated in the aggregate funding tracking system, upon supervisor approval the recipient will receive waivered services.

c. The agency will assure that diversion slots for CADI and BI-NF are within Southwest Health and Human Services' available allocations and will not exceed the number of allocations awarded by DHS.

d. The agency will assure the appropriate use of and monitor:
   - Conversion slots. Conversion slots may be requested as needed without reducing the assigned number of diversion allocations. Conversion slots are available to individuals leaving an institution after residing there for at least 30 days.
   - Diversion slots are awarded by DHS.

e. The agency will reuse slots when a current CADI or BI waiver recipient exits the waiver and is not expected to reopen the waiver within six months, if the cost of those services can be managed in the annual budget.

f. The case manager will verify the CFR. If the CFR gives a slot to an individual that is the responsibility of another agency, that agency will be giving a slot to the CFR.

g. Those not awarded a waiver slot will be referred to other state plan services and/or placed on the agency waiting list.

h. Southwest Health and Human Services is the sole decision making entity and Service Coordination entity. Requests for increases in funding for all consumers will be submitted to the supervisor via email or in writing. The supervisor will simulate the requests in the aggregate tracking system to determine if the funding is available. The CAC/CADI/BI staff will meet monthly with the supervisor for case consultation, program updates, and referral questions.

Section 4 – Priorities for Awarding CAC, CADI, and BI Allocations and Resources

a. A balance of the following priorities will be used to award allocations:

- Persons relocating from a nursing facility for CADI and BI-NF; long term care hospital for CAC and BI-NB.
- Persons relocating from a regional treatment center, IMD, Rule 36, or other institution.
- Persons at imminent risk of admission to a nursing facility, regional treatment center, and long term care hospital, RTC's, IMD's, Rule 36 licensed facilities or other institutions.
- Increases in service authorizations to assure health and safety of current recipients.
- Slot allocations and the necessary funding based on the individual's needs.
- CADI and BI waivers reuse slot allocations and necessary funding based on individual needs.
- Eligible persons in need of and waiting for home and community-based service alternatives.
- Southwest Health and Human Services may hold back a slot(s) for emergency needs.
- Other persons living in the community eligible for and choosing waiver services and need services that would otherwise be provided in a nursing facility or hospital.

b. Southwest Health and Human Services will review and consider the following in the decision for allocations and resources:

- Can the necessary supports and services in the CSP be accommodated by the waiver budget?
- Can Southwest Health and Human Services assure the health, safety, and welfare of the consumer and reasonably assure health, safety and welfare into the future?
- Can Southwest Health and Human Services and consumer access providers who meet standards and competency requirements stated in the CSP?
- Does Southwest Health and Human Services anticipate having a surplus at the end of the budget year?

- What budget reserves will be needed to meet anticipated or unanticipated changes in current recipient needs with the budget year?
- Southwest Health and Human Services considers its historical spending data and trends; the demographics of its current waiver population; and recent changes in law or other service programs that could increase demand for waiver services among current recipients. How will turnover in the programs impact the budget of the agency?

Section 5 – Process to Access CADI and BI Allocations

a. Southwest Health and Human Services will continue to identify and screen individuals who are eligible and in need of CAC, CADI, and BI Services. If Southwest Health and Human Services is not able to open the person, the individual is placed on the Wait List and the case manager enters the screening using the Assessment Result Code 27 (person placed on agency waiting list). Southwest Health and Human Services will maintain a waiting list of individuals eligible for and choosing but not yet able to access CADI or BI waivers. Southwest Health and Human Services will periodically reevaluate the needs, choices and options for those on the waiting list. Southwest Health and Human Services will prioritize those on the wait list consistent with priorities set by the State. For persons choosing to and waiting to relocate from institutions, Southwest Health and Human Services will work to assure that the waiting list moves at a reasonable pace.

b. All CADI and BI slot requests and any requests to increase the authorized amounts to CAC, CADI, and BI consumers to meet the health and welfare needs of the consumer will be given to the Social Services Supervisor for Southwest Health and Human Services using the CADI/BI request form. After reviewing and considering the criteria established by this policy, the supervisor will talk with the staff about the decision to award a waiver or refer elsewhere for other services that meet consumer need. Case managers will talk with the supervisor about increase in service allocation. The supervisor will work within the annual budget to see if the requested amount is manageable within the agency's annual budget and authorize or deny the request.

c. Verification of Agency of Financial Responsibility

d. Verification of Disability Certification will be submitted as part of the request process.

e. Obtain the diversion slot from the available allocations.

f. Enter the screening document into MMIS.

g. Case managers will complete an exit screening document and notify the supervisor of all exits from the waiver. Information will include the individual's name, the waiver type; Diversion, Conversion, CADI, or BI; date the individual left the waiver and expected date for reentry if that is the plan. To request a BIW-NB diversion slot, the case manager will submit the *Waiver request form.*

Section 6 – Individual Plan of Care

a. Southwest Health and Human Services will provide an assessment/screening that accurately reflects the person's level of need and supports. The agency will develop a Community Support plan (CSP) for each individual. The plan will identify the provision of the medically necessary services for the health and safety of the participant. The CSP will be based on assessed needs, include all waiver and State plan home care services, and provide an alternative to institutional placement. The plan must reasonably assure the consumer's health and safety, be authorized by the agency, and signed by the individual or their legal representative. The Community Support Plan will include standards, training and competencies needed in addition to minimally established State standards in order to deliver the necessary service for the individual. The plan will describe the type, amount, scope and duration of services and supports to be authorized. The agency has documentation that providers meet all licensure and certification standards and other qualifications identified in the CSP. Providers must deliver the services identified and required in the contract and CSP. The agency will monitor providers' performance per contract and service provision and if needed take corrective actions. The agency will comply with the obligation under law with regard to child or adult protection by reviewing reports from other agencies and will take action when necessary to assure vulnerable people are protected. Any change in the authorized services for an individual may not reduce services assessed as needed to assure the individual's health, safety and welfare.

b. If there are services identified that are not yet available, those services will be described. The CSP will be modified whenever there is a change of eligibility or significant changes in the needs or services planned.

c. Any changes to the Community Support Plan are based upon: the current need for funded supports and services; whether current authorizations are appropriate and agreed to by the consumer; the assurance that the plan continues to meet the health and welfare need of the individual and is in compliance with "Appeal/Notification Rights" for reductions not agreed to by the consumer.

Section 7 – Changes in the Level of Service

a. The case manager shall not authorize MA funding for waiver or State Plan home care services beyond the agency's budget. When considering denials, modification, reduction or terminations of home and community-based services for an individual, the case manager shall offer to meet with the individual or guardian in order to discuss the prioritization of service needs within the individualized plan of care. This meeting to discuss priorities must be documented in the consumer's case file. If an agency proposes to change the person's plan of care, all applicable notification and appeal rights apply. This information will be documented in the consumer's file. The case manager must offer to meet with the individual or individual's guardian in order to discuss the prioritization of service needs within the individual's community support plan and documented in the consumer's file. In the event of an appeal, waiver services (within federal waiver plan parameters) must continue until there is a decision made about the appeal or unless the parties can reach agreement. The reduction in the authorized services may not reduce services necessary to assure the individual's health, safety, and welfare or services that are needed to meet the objectives of the CSP.

Section 8 – Service Authorization

a. Goods and services authorized will be the least costly that reasonably meet the identified needs of the individual. Goods and services are for the sole benefit of the person and purchases must be directly related to an assessed need of the consumer. Reviews including evaluation of the individuals level of care, and reauthorizations of services will be completed annually and/or more often if the consumers' needs change or they request a review. The agency, through service agreements in MMIS, will complete the prior authorization process. Southwest Health and Human Services will maintain information sufficient to meet the needs of an audit. The Waiver Management System for CAC/CADI/BI will be utilized as a decision-making resource and management system.

Section 9 – Quality Assurance

a. Southwest Health and Human Services will submit a copy of their Resource Management policies and procedures every 5 years unless policies and procedures have been modified since submission. Southwest Health and Human Services will monitor services and consumers to assure health and safety issues are met. We will solicit regular feedback from recipients about the quality and satisfaction with services including case management/service coordination through a biannual satisfaction survey. The supervisor will review all surveys and immediately address any issues or concerns that arise. Southwest Health and Human Services will review the service system performance and needs. Southwest Health and Human Services will act upon any Quality Assurance recommendations for improvement.

SOUTHWEST HEALTH AND HUMAN SERVICES
SOCIAL SERVICE POLICY NUMBER 34

EFFECTIVE DATE: 07/17/13
REVISION DATE:
AUTHORITY: Southwest Health and Human Services – Human Services Board
Vulnerable Adult Act
Vulnerable Adult Rule

--- INVESTIGATION: MALTREATMENT OF A VULNERBALE ADULT ---

Section 1 – Purpose

a. It is the policy of Southwest Health and Human Services (SWHHS):
- To act as the Common Entry Point (CEP) for the reporting of Vulnerable Adult Maltreatment by calling the SWHHS Centralized Intake line 8:00 a.m. to 4:30 p.m. Monday through Friday excluding holidays and with each County Sheriff's office acting as CEP when the agency offices are closed.
- To provide investigations regarding reports of maltreatment of a vulnerable adult.
- To provide an assessment and offer protective services.

Section 2 – Process

a. Upon receiving an adult maltreatment report to our Centralized Intake the CEP and maltreatment data is input into the Social Service Information System (SSIS) and forwarded to the appropriate lead investigative agency including; Department of Health, Department of Human Services Licensing, the County or Law Enforcement if criminal activity is suspected.

b. In cases where the agency is lead investigative agency the Adult Protective Unit/Adult Services staff will assess and offer emergency protective services for the purpose of preventing further maltreatment and for safe guarding the welfare of the vulnerable adult.

c. In cases of suspected physical/sexual abuse the agency shall immediately arrange for emergency protective services and make available to the vulnerable adult appropriate medical examination and treatment.

d. The initial assessment may require immediate gathering of information by phone contacts with collateral sources. Serious reports that may involve imminent danger may require immediate direct contact with the vulnerable adult by an adult services social worker. Serious reports must have direct contact with the vulnerable adult by the end of two working days unless supervisory approval has been secured.

e. The agency, when necessary, in order to protect the vulnerable adult from serious harm shall immediately intervene by:

- Calling 911 if the vulnerable adult is in a life threatening situation.
- Assist the vulnerable adult in obtaining a restraining order or court order for removal of the perpetrator pursuant to Minnesota Statutes, Section 525.539.
- Assist with the appointment of a Guardian/Conservator pursuant to Minnesota Statutes, Sections 525.539 to 525.6198 or Chapter 252A.
- Assist with the removal of a Guardian/Conservator.
- Recommending to medical or law enforcement staff the need for a hold order or commitment pursuant to the Minnesota Hospitalization and Commitment Act, Minnesota Statutes, Chapter 253A.
- Make a referral to the county attorney for possible criminal persecution of the perpetrator under Minnesota Statute, Chapter 609.

Section 3 – Prioritizing Vulnerable Adult Reports

a. Upon receiving a report from the CEP a determination will be made if the report is valid and requires an investigation. The CEP which requires an investigation by the agency will be prioritized by using the Structured Decision Making System (SDM) as soon as possible and signed off by the supervisor.

b. Intake Assessment: The assigned worker will complete the intake assessment tool in the SDM system on all reports of maltreatment that are screened in for investigation to determine the response priority.

- Level 1 : initiate within 24 hours from assignment for investigation
- Level 2 : initiate within 72 hours from assignment

c. Safety Assessment: The assigned worker will begin the investigation according to the Level 1 or Level 2 recommendations. A visit will be made and the safety assessment is completed and entered into the SDM tool.

d. Strengths and Needs Assessment: An initial strengths and needs assessment will be completed at the first face to face contact with the vulnerable adult to determine the strengths and needs of the client and a safety plan will be made. A closing strengths and needs assessment will be completed prior to closing the case to ensure needs are being addressed and determine other referrals that need to be made. The supervisor will sign off.

Section 4 – Training

a. It is the policy of SWHHS that adult social service staff receive regular training on how to protect a frail or vulnerable adult, how to report abuse, neglect or exploitation of a vulnerable person and mandated reporter responsibilities. The lead investigators are to receive a minimum of 8 hours of continuing education or in-services training each year in the following areas.

- Training and be knowledgeable in:
  - Common Entry Point (CEP) intake responsibilities and mandated reporter responsibilities
  - Investigative techniques, adversarial interviewing techniques, and record keeping
  - The MN Vulnerable Adult Act
  - Assessment procedures
  - Adult protection resources and case management practices
  - SSIS and Structured Decision Making tools

Section 5 – SSIS/Documentation

a. All information and case work related to the CEP and adult protection investigations is now captured in the Social Service Information System (SSIS). Staff will use SSIS to record Vulnerable Adult (VA) reports received through the CEP process. The CEP is required to enter all maltreatment data into SSIS and forward the report to the appropriate lead investigative agency.

b. During the investigative process the investigating worker shall conduct interviews with the alleged perpetrator, the victim, and other persons who may be knowledgeable or have information concerning maltreatment of vulnerable adults. The adult protection worker and supervisor responsible for the investigation shall determine who may be present in an interview. If an alleged perpetrator will not participate in the interview without an outside person present, a determination may be made without completing an interview with the alleged perpetrator.

c. After the investigation is complete and if the report is substantiated the adult services worker will complete the required notice of findings letters within SSIS and close the APS investigation case. If ongoing adult protective services are needed the case will be opened for ongoing case management services.

<u>Agency Forms Regarding this Policy:</u>
SS#267 – Common Entry Point Intake for Vulnerable Adult

SOUTHWEST HEALTH AND HUMAN SERVICES
ADMINISTRATIVE POLICY NUMBER 19

EFFECTIVE DATE: 07/17/13
REVISION DATE:
AUTHORITY: Southwest Health and Human Services Joint Governing Board

--- REMOTE ACCESS ---

Section 1 - Purpose

a. This policy is intended to operate in conjunction with the Agency Board approved LAN, Email, Internet Access, and Personal Computing Policy; Administrative Policy Number 10.

b. The Agency recognizes the importance of utilizing technology to increase employee productivity, improve employee satisfaction, reduce employee absenteeism, and provide greater employee access to data throughout the Agency. The effective use of technology to promote the mission of Southwest Health and Human Services may require that staff be able to access data and information from remote locations.

c. To accomplish that, the Agency supports remote access as a tool for Agency employees, as deemed appropriate by their supervisor and Division Director. The Agency's Remote Access program is intended to be an Agency employee service that benefits the Agency, constituents, and employees.

Section 2 - Definitions

a. Remote Access - communication with the Southwest Health and Human Services network system and applications from a remote location or facility through a secure, Southwest Health and Human Services assigned/approved data link.

b. Remote Access Employee - an employee, as a part of their regular job description, requires work to be done at a remote work site, rather than at a Southwest Health and Human Services owned or leased office space, who has been approved for remote access status by the department head and has successfully completed the Agency's remote access training program.

c. LAN, Email, Internet Access, and Personal Computing Policy - A document that describes the Agency's electronic security requirements and details employee's responsibilities when using Agency owned equipment and systems.

d. Core Hours - those hours during which the employee must be available for contact.

e. Remote Access Agreement - a document, signed by the remote access employee, Division Director and IT , that describes specific obligations and terms agreed to between the employee, department head and IT.

f. Confidential Data Agreement - a document, signed by the remote access employee, that details the employee's commitment to comply with the Minnesota Data Practices Act and other State or Federal law with respect to data collected, created, received, maintained or disseminated by remote access.

g. Telecommuting - an approved work arrangement for remote access employees that enables them to work part of the standard work week at an alternative work site, on a regularly scheduled basis, rather than at their normal Southwest Health and Human Services office/location.

Section 3 - Employee Selection, Criteria and Conditions

a. The supervisor and Division Director will review and approve/deny each remote access request on a case-by-case basis. Either the employee, supervisor or the Division Director may initiate a request. The supervisor or Division Director will consider the unique circumstances of each request in light of the factors listed below:

- Needs of the department.
- Availability and costs of needed equipment.
- Effect on customer service.
- Employee's computer and technology skills as required for remote access.
- Effect on the rest of the work group, unit or department.
- Other items deemed necessary and appropriate by the Department Head.

b. Seniority will not be a basis for selecting employees to participate in this program.

c. The granting, withdrawal, and denial of remote access privileges are the exclusive prerogative of the Agency. Those privileges shall not be an entitlement of employees. Decisions granting, withdrawing, or denying those privileges shall be made on a case-by-case basis by Department Supervisors, Division Director with the input from IT, consistent with the mission of the Agency and the respective department.

d. Remote access is not a telecommuting policy or an agreement to provide a right to an alternative work site on either a regularly scheduled or temporary basis, and does not provide authorization for an employee to telecommute.

Section 4 - Access and Use of System

a. Employees shall only use remote access during scheduled work hours, agency travel, or when preapproved to perform during non-traditional hours. The system shall not be used for casual use.

Section 5 – Remote Access Agreement

a. A Remote Access Agreement is required between the Division Director, IT, and remote access employee. In the event that the Division Director requests remote access employee status for him/herself, the agreement will be between the Director and IT Services.

Section 6 – Equipment and Information Security

a. Remote access employees will be provided with Agency owned equipment for the purpose of remote access. Depending on the job and departmental resources, equipment needs for remote access will vary. Equipment needs will be determined by the supervisor, Division Director, employee, and IT Department staff on a case-by-case basis.

b. Remote access employees shall use Agency provided secure gateway connection to the Agency Information Network using an Agency provided technology. They shall abide by the Agency's LAN, Email, Internet Access, and Personal Computing Policy including but not limited to those provisions governing information security, remote access, software licensing, copyrights, trademarks, trade-secrets, the requirements set forth in the MN Government Data practices Act, as well as Federal and State privacy regulations. The cost and maintenance of the secure gateway and any necessary networking equipment and/or software will be the responsibility of the Southwest Health and Human Services IT Department.

c. The Agency will be responsible for the maintenance of Agency provided equipment and the security of the Southwest Health and Human Services Information Network. The Agency will replace lost, damaged, or stolen Agency owned equipment only, provided the employee has taken appropriate precautions to safeguard the equipment. It is the responsibility of the employee to report, to the IT Department, any error messages, virus alerts, any suspicious activity, any/all security breaches, equipment problems or equipment loss as soon as they occur.

d. Southwest Health and Human Services will provide information to the remote access employee regarding appropriate firewall, anti-virus, spy-ware and connectivity software to meet Southwest Health and Human Services security and protection requirements and will provide training to the employee with regards to its operation. It is the responsibility of the employee to report any security or virus concerns, errors, messages, etc. to the IT Department as soon as they occur.

e. Remote access employees shall not use Agency provided equipment or Agency Internet gateway for personal use nor allow non-Agency employees to use Agency owned equipment or access the Agency information network or data derived there from at any time. All personal use of the Internet shall be accessed outside the Agency network in compliance with the Southwest Health and Human Services Acceptable Use for Electronic Communications component of the Code of Ethics policies.

f. Remote access employees shall ensure that no one has access to the employee's key fob and/or password, which allows access to the Agency information network, if the security fob is lost or stolen, it shall be reported immediately to the IT Department to ensure security of the Agency network/systems.

g. Remote access employees shall abide by data privacy rules set forth in the Minnesota Government Data Practices Act and Health Insurance Portability and Accountability Act (HIPPA). Agency information shall be kept secure at the remote access location. Any private information needing to be destroyed shall be returned to the Southwest Health and Human Services IT Department and disposed of properly.

h. Remote access employees must return all Agency owned equipment to the Agency when requested by their supervisor, Division Director or IT, or when employment with the Agency is terminated. That equipment shall be returned to the Agency Department in which the employee is affiliated with or to the Agency IT Department as soon as practicable, and in all events within five business days of the request.

Section 7 – Withdrawal and Termination of Remote Access Privileges

a. Nothing in this policy is intended to create any right or any interest whatsoever in or to remote access privileges by any Agency employee. The granting, denial, termination, or withdrawal of remote access privileges shall be made at the will of the supervisor, Division Director or the Director at any time, with or without cause, and without any notice or hearing. The date of withdrawal of privileges, should that occur, is to be documented on the Remote Access Agreement of the employee, which is kept in the employee's personnel file.

Agency Forms Regarding This Policy
AG#027 – Remote Access Agreement

Southwest Health and Human Services
Remote Access Agreement

Ag#027 06 13

Southwest Health and Human Services (SWHHS) recognizes that the information and equipment on its networks is a valuable asset that must be protected from inappropriate acts or omissions. At the same time, effective use of technology to promote the mission of SWHHS may require that staff be able to access data and information from remote locations. SWHHS will, with proper authorization and access standards, provide SWHHS staff and others so approved, remote access to its internal network via methods that provide information security and protection and are approved by the department head in coordination with the SWHHS IT.

REMOTE ACCESS TERMS

AS A SWHHS REMOTE ACCESS EMPLOYEE, I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I agree to perform services for SWHHS ("the Agency") as a Remote Access Employee.

2. I agree that my duties, obligations, responsibilities, and conditions of employment with the Agency remain unchanged.

3. I agree that my work hours, overtime compensation, if any, vacation, sick leave and other terms and conditions of employment will conform with the current collective bargaining agreement and/or personnel policy, which ever apply to meet the terms agreed upon with my Supervisor.

4. In the event of an equipment malfunction, loss of equipment, security breach, or any other issues detailed in Section F, Item 3 of the Remote Access Policy, I agree to notify my Supervisor or the IT Department immediately.

5. I agree to restrict use of Agency provided equipment, software, and data to solely my use for purposes of conducting SWHHS business.

6. I agree that authorized Agency representatives, Department Head, supervisors, the IT Department and/or departmental designee can randomly request to inspect Agency owned equipment, data, and/or supplies. I agree to permit inspections upon request.

7. I agree to return all Agency owned equipment, software, products, documents, and data if I leave my employment with SWHHS or I am requested to do so by my supervisor. I agree to reimburse the Agency for any of the foregoing that is not returned or is damaged due to my negligence.

8. I agree to abide by the Agency's policies covering information, security, software, licensing and data privacy, the requirements set forth in the MN Data Practices Act, Health Insurance Portability and Accountability Act (HIPAA), and any applicable Federal and State privacy laws and regulations.

9. I understand that the SWHHS IT Department is not responsible for working on any employee owned equipment.

10. I agree that products, documents, reports, or data created as a result of my work related activities are owned by the Agency and governed by data privacy practices.

11. I agree to comply with all Federal and State laws, and Agency policies, including, but not limited to, the Acceptable Use Policy of the SWHHS Code of Ethics, the Remote Access

Policy and the Confidential Data Agreement. I understand that failure to comply may result in loss of remote access privileges and/or disciplinary measures up to and including termination. Any person or organization authorized remote access to SWHHS information shall:

- Comply with the SWHHS Acceptable Use Policy LAN, Email, Internet Access, and Personal Computing Policy.
- Maintain the highest standards to protect any data, passwords, software, and computers that enable remote access to the SWHHS network.
- Remove, upon termination of employment or the project, all software, data, or other enabling technology that was provided by SWHHS for the purpose of remote access
- Have read and agree to fully comply with the Acceptable Use Policy of the SWHHS Code of Ethics, Remote Access Agreement, and Confidential Data Agreement as a condition of employee remote access to the SWHHS information system(s).
- Assure that unauthorized persons, including family members, will not have access to any computer that has been configured to remotely access the SWHHS network or to the data stored on the computer or network.

I have read, understand and am fully aware of the terms of the SWHHS Remote Access Policy, the Remote Access Terms and the Acceptable Use Policy of the SWHHS Code of Ethics, especially as applied to remote users of the Agency's information systems; and I agree to comply with the terms of this policy. I also agree to remain informed of and comply with future revisions to the policy.

I have attended and completed the Remote Access Training provided by SWHHS IT Department:

Location: _____ Date: _____

Remote User Name (print): _____

Signature: _____ Date_____

Supervisor and Division Director Approval Authority

Name and Title (print): _____

Signature: _____ Date_____

Name and Title (print): _____

Signature: _____ Date_____

IT Completion

Name and Title (print): _____

Signature: _____ Date_____

SOUTHWEST HEALTH AND HUMAN SERVICES
PERSONNEL POLICY NUMBER 2

EFFECTIVE DATE: 01/01/11
REVISION DATE: 07/17/13
AUTHORITY: Southwest Health and Human Services Joint Governing Board

- - -CONDITIONS OF EMPLOYMENT- - -

Electronic copies of the Personnel Policies shall be available for employees in each office. Employees shall be responsible for reviewing and abiding by the terms of the Personnel Policies.

Section 1 - Workweek

a. The standard workweek for full time employees shall be 8:00 a.m. to 4:30 p.m. daily, 37.5 hours per workweek. The Agency's workweek is declared to be a seven consecutive day period commencing on Monday and ending on Sunday.

Section 2 - Working Hours

a. Standard working hours shall be seven and one-half (7.5) hours daily, five (5) days a week. Immediate supervisors may require employees to work other schedules based on the nature of their assignments.

b. Employees who work a standard seven and one-half (7.5) hour day are entitled to one (1) fifteen (15) minute break before noon and one (1) fifteen (15) minute break in the afternoon which shall be paid.

c. One (1) hour unpaid lunch breaks are to be taken between 11:00 a.m. and 2:00 p.m. The office will remain open during the noon hour with staggered lunch hours by the employees.

d. Neither coffee breaks nor lunch hours can be saved up to earn comp time if they are not taken by the employee. The only time lunch hours may be reduced to 30 minutes is during flex time or when an employee is authorized to make up work time that was lost due to a snow storm.

Section 3 – Employee Definitions

a. Probationary Period – The first year of employment with the agency, during which the employee shall receive orientation and new employee training. For employees promoted to a new position, the probationary period shall be six (6) months.

b. During the probationary period, the employee shall receive a heightened amount of supervision and additional performance evaluations. Probationary employees shall not

Section 7 - Flex Time

a. There are circumstances when deviation from regular service hours (aka flextime) will be considered for an employee. The below CRITERIA must be met BEFORE any deviation from the regular work schedule may be considered or authorized. Said criteria are as follows:

1. Client service and the operation of the unit/division and department must continue to be efficient and effective.
2. There must be no negative impact on co-workers or interference with inter-divisional activities or operations.

b. If employees wish to work a flex schedule, they must follow the process determined by the unit supervisor. All schedules are subject to supervisory approval. It may be necessary for the supervisor to make some adjustments in the requests to ensure adequate coverage of the agency.

c. During the hours between 8:00 a.m. and 4:30 p.m. whenever an employee is absent from the office due to their flex schedule or other leave time, it should be shown as "flex" or "personal leave" on their calendar.

d. It is anticipated that with good effort at scheduling, the need for comp time should be reduced. The scheduled work week cannot be more than 37.5 hours.

e. The longest day that will be scheduled is 9.5 hours. The number of hours of vacation or medical leave taken will be the number of hours scheduled to work on that specific day. Coffee breaks are to be 15 minutes in length with one in the morning and one in the afternoon. The minimum lunch break will be one-half hour.

f. The supervisor may require a person on a flex time schedule to return to standard work hours at the supervisor's discretion.

g. It is not permissible to utilize a four-day flex time schedule during a holiday week. Employees will work 7.5 hours per day during these holiday weeks.

h. It is not permissible to flex a Friday and the following Monday.

i. Upon notice of resignation, that employee will not work a flex schedule for the ~~balance~~ last 2 weeks of the employee's employment with the agency.

SOUTHWEST HEALTH AND HUMAN SERVICES
PERSONNEL POLICY NUMBER 3

EFFECTIVE DATE: 01/01/11
REVISION DATE: ~~11/16/11~~08/01/13
AUTHORITY: Southwest Health and Human Services Joint Governing Board

- - -LEAVES AND HOLIDAYS- - -

Section 1 – Vacation Leave

a. Each permanent or probationary full-time employee shall earn, on the last working day of each payroll period:
   - 3.7 hours of vacation leave for 1 - 5 years of service
   - 5.55 hours of vacation leave for 6 - 9 years of service
   - 6.45 hours of vacation for 10 - 14 years of service
   - 7.35 hours of vacation leave for 15+ years of service

b. Vacation leave will be prorated for part-time employees. Part-time employees, or employees whose status has changed from part-time to full-time (or vice-versa), are not eligible for automatic increases based upon years of service. Any increase in vacation leave is based upon total months of service.

c. Vacation leave can accumulate to a maximum of 224 hours. No time is accumulated after reaching the maximum. Vacation leave cannot be used during the first three months of full-time equivalency service. When taking vacation leave, the minimum increment that can be used is one-half hour. Vacation leave cannot be used until it is earned.

d. Requests for vacation leave must be made to the employee's supervisor in writing and must be authorized in advance by the supervisor in writing.

e. Upon voluntary separation of employment, any employee who has six (6) months of satisfactory service will be paid for any accrued vacation leave that has not been used. Employees may not use more than three (3) days during the last two weeks of employment. Employees terminated for misconduct shall not be entitled to be paid accrued unused vacation leave. This shall not apply to employees terminated for poor work performance.

f. Employees who were previously employed by Lincoln, Lyon, and Murray Human Services and Lincoln, Lyon, Murray, and Pipestone Public Health or a County that becomes a member of Southwest Health and Human Services, shall maintain their seniority dates from their initial employment, so long as there was no interruption in continuous employment from their prior employer and Southwest Health and Human Services.

Section 2 – Medical Leave

a. Each probationary, temporary, and permanent employee shall earn medical leave at the end of the payroll period at the rate of 3.7 hours. Medical leave will be prorated for part-time employees. Medical leave can accumulate to a maximum of 450 hours. No time is accumulated after reaching this maximum. Medical leave may not be used in the payroll period it is earned.

b. When taking medical leave, the minimum increment that can be used is one-half hour. In addition, the agency may designate any qualifying leave for employee or family medical purposes, paid or unpaid, as counting toward an employee's FMLA entitlement (FMLA § 825.208).

c. Medical leave may be used for illness (self and immediate family), injury, medical and dental appointments. (Immediate family shall be spouse, children, parents, grandparents and legal wards of the employee or as allowed by state statute). Medical leave may be used for reasons of prenatal and postnatal care for the length of time prescribed, and verified in writing, by a physician.

d. When an employee cannot report to work due to an illness the employee shall notify the receptionist so the employee's calendar can be updated. The receptionist should then notify the supervisor so that unit coverage is ensured.

e. When illness occurs within a period of vacation leave, the period of illness may be charged as medical leave and the charge against vacation leave reduced accordingly.

f. No employee will be paid for accrued medical leave at the time of separation, except those employees in the Public Health Collective Bargaining Unit. Payment of unused medical leave will be paid out to the Public Health Collective Bargaining Unit as per the Collective Bargaining Agreement.

g. The employer may require medical documentation when three days of leave are used within a thirty (30) day period. Such documentation may consist of verification of doctor's or dental appointments without disclosure of diagnosis. The employer reserves the right to request additional information, including medical information, in the event that there is a pattern indicating the possible abuse of sick leave.

h. Medical leave due to preplanned medical appointments must be approved by the employee's supervisor in the same manner as vacation.

i. If any employee receives a compensable injury and has benefits accrued under sick leave, the employee may at his/her option, request and receive sick leave to supplement the difference between his/her regular pay and Worker's Compensation.

JULY 2013
BOARD APPROVAL ON THE FOLLOWING:

☐ **Western Mental Health Center (Marshall, MN)** – 07/01/13 to auto renewal; A mental health agreement to provide client diagnostic assessments for referrals for nursing home care, rate $205 (masters) or $230 (doctoral), and review records and make collateral contacts, rate $140/hr (masters) or $150/hr (doctoral), and travel at $.485/mile (new).

☐ **Community Health Information Collaborative (CHIC) HIE-BridgeDirect (Duluth, MN)** – Effective upon signature to auto renewal; Health Information Exchange that allows providers to securely share patient information with other participating organizations through authenticated user access, rate $0 (new).

☐ **Clearway Minnesota (Minneapolis, MN)** – 07/01/13 to 06/30/14; Grant to reduce tobacco use and secondhand smoke exposure through research, action, and collaboration, $149,994 maximum paid out in installments based on reporting (renewal).

☐ **Public Health Emergency Preparedness (PHEP) (MDH)** – 07/01/13 to 06/30/17; Grant for public health emergency preparedness, $114,000 for budget period 07/01/13 to 06/30/14 (renewal).

☐ **SHIP (MDH)** – 01/01/12 to 10/31/13; Amendment to extend the expiration of the grant from 06/30/13 to 10/31/13, allocation remains the same at $432,044, (extension).

☐ **Heritage Pointe Senior Living (Marshall, MN)** – 08/01/13 to 12/31/14; Home Community Based Services contract for a new facility that provide assisted living and customized living services for clients (new).

OLD ONE

AMENDMENT TO JOINT POWERS AGREEMENT SOUTHWESTERN MINNESOTA ADULT MENTAL HEALTH CONSORTIUM

This AMENDMENT TO JOINT POWERS AGREEMENT (the "Amendment Agreement") is made and entered into this 2 day of November 2012, by and between the counties of Rock, Nobles, Jackson, Pipestone, Cottonwood, Redwood, Yellow Medicine, Renville, McLeod, Lac Qui Parle, Chippewa, Big Stone, Swift, Kandiyohi, Meeker, Lincoln, Lyon and Murray (collectively the "Counties").

RECITALS

A. The Counties entered into that certain Joint Powers Agreement dated December 27, 2001 (the "JPA");

B. The parties desire to amend and clarify certain provisions of the Agreement.

NOW, THEREFORE, in consideration of the promises and the mutual agreements of the Agreement, and of those herein contained, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

Article III, Section 2, Sub-Section 2 of the JPA shall be amended and restated as follows:

2. The structure of the Advisory Board shall consist of dividing the 18 counties into two regions, a northern and a southern, and then, ~~as shown in the following table,~~ further dividing each region into three groups of three counties each. County designation to the individual groups is outlined in the Operating Bylaws. The Governing Board shall have the authority to recommend county changes to the individual group and present to the Executive Commissioners Board at the Annual Board meeting for final approval.

Northern Region: Big Stone, Chippewa, Lac Qui Parle, Kandiyohi, McLeod, Meeker, Renville, Swift, Yellow Medicine			Southern Region: Cottonwood, Jackson, Lincoln, Lyon, Murray, Pipestone, Redwood, Rock, Nobles		
Group 1	Group 2	Group 3	Group 1	Group 2	Group 3
~~Big Stone~~ ~~Lac Qui Parle~~ ~~Yellow Medicine~~	~~Chippewa~~ ~~Swift~~ ~~Kandiyohi~~	~~Renville~~ ~~Meeker~~ ~~McLeod~~	~~Lincoln~~ ~~Lyon~~ ~~Murray~~	~~Pipestone~~ ~~Rock~~ ~~Nobles~~	~~Redwood~~ ~~Cottonwood~~ ~~Jackson~~

AMENDMENT TO
JOINT POWERS AGREEMENT
SOUTHWESTERN MINNESOTA
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Group 1	Group 2	Group 3	Group 1	Group 2	Group 3

IN WITNESS WHEREOF, the parties hereto have caused this Amendment Agreement to be executed as of the day and year first above written.

ARTICLE XIII. AUTHORIZATION:

IN WITNESS WHEREOF, the following counties, by virtue of the duty authorized signatures set forth below, have authorized the execution of this Agreement to be effective as of the 2nd day of November 2012

LINCOLN, LYON, MURRAY COUNTY

BY_____
CHAIRPERSON, SOUTHWEST HEALTH AND HUMAN SERVICES BOARD

_____
DATE

Approved as to form and execution

_____
AGENCY ATTORNEY