

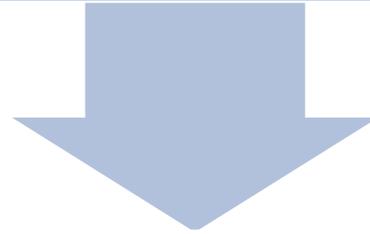
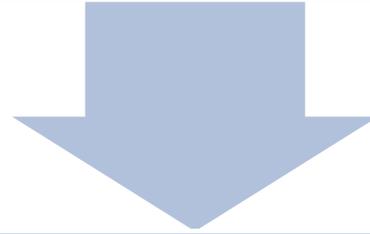
Timelines for service access

January 2015

**Timeline to
Access to
DD Services**



Steps prior to
Eligibility
Determination



Completed Application

OAR 411-320-0080(1)(a)

To apply for developmental disability services:

(A) An applicant or the legal representative of the applicant must submit a **completed application** as defined in OAR 411-320-0020 to the CDDP in the county of origin as defined in OAR 411-320-0020;

Completed Application

OAR 411-320-0020(25)

"Completed Application " means an application required by the Department that:

- a) Is filled out completely, signed, and dated. An applicant who is unable to sign may sign with a mark, witnessed by another person; and
- b) Contains documentation required to make an eligibility determination as outlined in OAR 411-320-0080(1)(a)(B).

Intake

OAR 411-320-0020(54)

"Intake" means the activity of completing the DD Intake Form (SDS 0552) and necessary releases of information prior to the submission of a completed application to the CDDP.

Intake = SDS 0552 + Releases of Information

Documentation of DD

- Eligibility specialist has 90 days from intake to collaborate with individual to gather necessary information to complete the application
 - OAR 411-320-0080(10)(b)
- Process may be extended an extra 90 days
 - OAR 411-320-0080(10)(b)(C)
- CDDP may stop the intake process at 90 days and send written notification of the information needed to complete the application
 - OAR 411-320-0080(1)(b)

Documentation of DD

OAR 411-320-0080(1)(a)(B)

Documentation includes, but is not limited to:

- i. All school psychological or comprehensive evaluations since entry into school;
- ii. All medical assessments related to a disability, mental health condition, or physical impairment;
- iii. All psychological evaluations or comprehensive evaluations through private health insurance or other programs;
- iv. All neurological evaluations completed through any entity;
- v. All records from all residential or psychiatric facilities;
- vi. Records completed through application process for other governmental benefits; and
- vii. Administrative medical examinations and reports, as defined in OAR 410-120-0000, determined necessary and authorized by the eligibility specialist.

Steps prior to
Eligibility
Determination



Timelines During an Eligibility Determination

Once an application is complete:

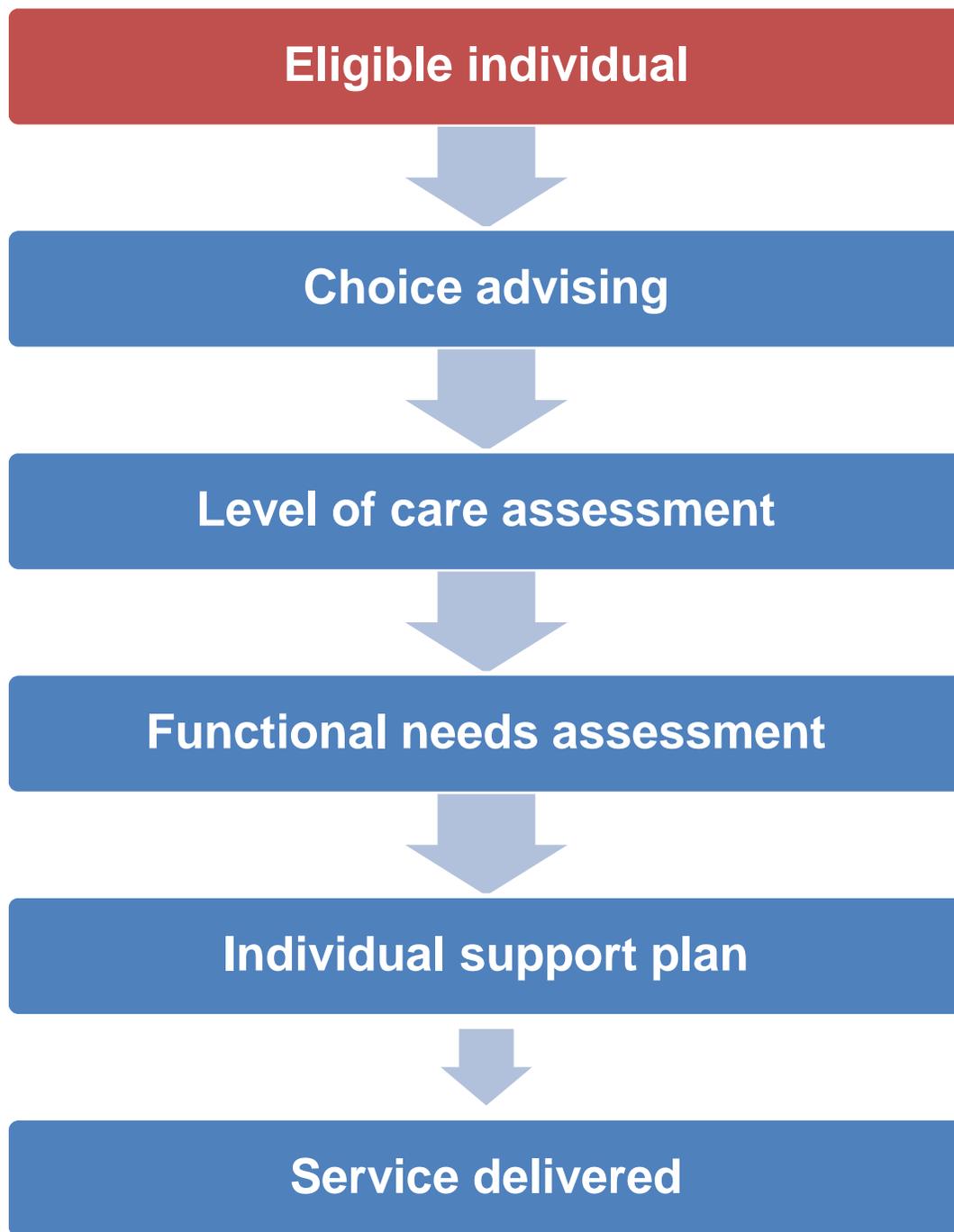
- Eligibility specialist makes a determination and CDDP must send or hand deliver a written Notice (5103 or 9407) **within 10 days of completed application**
 - OAR 411-320-0080(11)
- CDDP must provide the Notification of Rights (SDS 0948) **within 10 business days**
 - OAR 411-320-0080(1)(d)

Access to DD services

If eligible, the following applies in this specific order:

1. **Choice advising** prior to (or concurrent with) the Level of Care assessment
2. **Level of Care** assessment
 - Must be completed prior to or same date as FNAT
3. **Functional Needs Assessment (FNAT)**
 - Must be completed after or on same date as LOC
4. **Individual Support Plan (ISP)**
 - No more than **90 days from the date a completed application**

Access to
DD Services



Individuals' Rights – Choice Advising

OAR 411-320-0060

(4) While receiving developmental disability services, an individual has the right to:

(p) Ongoing opportunity to participate in the planning of services in a manner appropriate to the capabilities of the individual, including the right to participate in the development and periodic revision of the plan for services, **the right to be provided with a reasonable explanation of all service considerations through choice advising**, and the right to invite others chosen by the individual to participate in the plan for services;

Choice Advising

OAR 411-320-0020(22)

"Choice Advising" means the impartial sharing of the following information to individuals with intellectual or developmental disabilities provided by a person that meets the qualifications in OAR 411-320-0030(4)(c):

- (a) Case management;
- (b) Service options;
- (c) Service setting options; and
- (d) Available providers.

- See “choice” in OAR 411-320-0020(21) and 411-340-0020(22)
- May be completed by Services Coordinator or Personal Agent (see OAR 411-340-0020(23))

Choice Advising – Case Management Responsibilities

OAR 411-320-0090(4)(I)

CDDP must describe case management and other service delivery options within the geographic service area provided to all individuals receiving case management from the CDDP.

- A. Must occur **at least 6 months before** the 18th birthday of a child
- B. For newly eligible individuals, must occur **prior to, or concurrent with, Level of Care**
- C. Within 10 days** of moving into County
- D. Must be provided initially and at least annually thereafter
 - must include informing the individual of the right to request access to other available services
 - documentation required in service record
- E. If not eligible for Community First Choice state plan or waiver services, initial choice advising must also inform the individual of their the right to access case management from the CDDP or a support services Brokerage.

OAR 411-320-0070(3)(a)(F)

Information contained in the service record must include documentation of initial, annual, and requested choice advising

Choice Advising - Support Service Brokerage Services

OAR 411-340-0120(7)

- Choice advising regarding the provision of case management and other services must be provided to individuals who are eligible for, and desire, developmental disability services.
- Choice advising must be provided **at least annually**.
- Documentation of the discussion must be included in the service record for the individual.

Access to
DD Services

Choice advising



Level of care assessment



Functional needs
assessment



Individual Support plan



Service delivered



Level of Care

OAR 411-320-0020(64)

OAR 411-340-0020(71)

Means an individual meets the following institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities:

- (a) The individual has an intellectual disability or a developmental disability as defined in this rule and meets the eligibility criteria in OAR 411-320-0080 for developmental disability services; and
- (b) The individual has a significant impairment in one or more areas of adaptive behavior as determined in OAR 411-320-0080.

A level of care determination may be made by a services coordinator or a personal agent – OAR 411-320-0120(2)(d)

LOC – Case Management Program Responsibilities

OAR 411-320-0090

OAR 411-320-0090(4)(s) – **When SC completes LOC**, must ensure that OHP Plus and OSIP-M eligible individuals are:

- Offered and advised of all services available for which they are eligible including, but not limited to, the choice of institutional or community based care, home and community-based waiver and Community First Choice state plan services;
- Provided a Notification of Hearing Rights (form SDS 0948);
- Have a completed level of care determination that is **reviewed annually or at any time there** is a significant change in factors that contribute to the level of care.

OAR 411-320-0070 – LOC must be in the service record

LOC – Service Planning OAR 411-320-0120(2)

- a) SC must assure that an individual has a LOC determination **prior to accessing Community First Choice state plan or waiver services.**
- b) SC must assure that a LOC determination is reviewed for every individual enrolled in a comprehensive service:
 - A. Within 12 months** from the previous Annual Review;
 - B. No earlier than 60 days prior** to the renewal of the ISP;
 - C. Any time there is a significant change in a condition that qualified the individual for the level of care.
- c) LOC assessment must be documented in a progress note in the service record for the individual.

OAR 411-320-0110 Entry Exit Requirements

(8)(d)(B) SC must communicate with the Brokerage staff and provide all relevant information . . . including a *completed LOC determination, if present.*

LOC – Support Service Brokerage Services

OAR 411-340-0120(8)(a)

The Brokerage must assure that an individual who is eligible for OHP Plus or OSIPM or who becomes eligible after entry:

- (A) Receives a LOC determination **prior to** accessing services and prior to an initial FNAT;
- (B) Is offered the choice between home and community-based services or institutional care;
- (C) Is provided a notice of fair hearing rights (SDS 0948); and
- (D) Has the LOC reviewed **annually not more than 60 days prior to the renewal of the ISP**, or at any time there is a significant change in a condition that qualified the individual for the LOC

Access to
DD Services

Choice advising



Level of care assessment



Functional needs
assessment



Individual support plan



Service delivered



Functional Needs Assessment

OAR 411-320-0020(42) and OAR 411-340-0020(53)

"Functional Needs Assessment" means the comprehensive assessment or reassessment appropriate to the specific program in which an individual is enrolled that:

- a) Documents physical, mental, and social functioning;
- b) Identifies risk factors and support needs; and
- c) Determines the service level.

OAR 411-340-0020(53)(b) *The FNAT for an adult enrolled in a support services brokerage is known as the Adult Needs Assessment (ANA). The Department incorporates Version B of the ANA dated July 1, 2014 into these rules by this reference. The ANA is maintained by the Department*

Functional Needs Assessment

OAR 411-320-0060(4) – Individuals' Rights

While receiving developmental disability services, an individual has the right to:

- (n) Seek a meaningful life by choosing from available services, service settings, and providers consistent with the support needs of the individual identified through a **functional needs assessment** and enjoying the benefits of community involvement and community integration

OAR 411-320-0070(3)(a)(E) – Service records

Must include documentation of the **functional needs assessment** defining the individual's support needs for ADL, IADL and other health-related tasks

OAR 411-320-0110(3)(F) Entry and Exit Requirements

Prior to entry SC (or designee) must provide a copy of the **most recent needs assessment**. If the needs of an individual have changed over time, the previous needs assessments must also be provided;

FNAT – Service Planning

OAR 411-320-0120(3) and OAR 411-340-0120(9)

SC or PA must complete a FNAT initially and **at least annually** for each individual who has or is expected to have an ISP. (a) The FNAT must be completed:

- A. Not more than **45 days from the date that the individual submitted a completed application** or the date the individual became eligible for OHP Plus or OSIPM.
- B. Prior to** the development of an initial ISP;
- C. Within 60 days prior to** the annual renewal of an ISP; and
- D. Within 45 days from** the date an individual requests a FNAT re-assessment.

FNAT – Service Planning

OAR 411-320-0120(3)(b) and OAR 411-340-0120(9)(c)

An adult who is enrolled in comprehensive in-home supports as described in OAR chapter 411, division 330 or a child who is enrolled in in-home supports as described in OAR chapter 411, division 308 **must participate in a FNAT and provide information necessary to complete the FNAT** and reassessments within the time frame required by the Department.

- A. Failure to participate in the FNAT** or provide information necessary to complete the FNAT or reassessment within the applicable time frame results in the denial of service eligibility (must send NOPA and cite this rule)
- B. The Department **may allow additional time if** circumstances beyond the control of the individual prevent timely participation in the FNAT or timely submission of information necessary to complete the FNAT or reassessment.
- C. No fewer than 14 days prior to conducting a FNAT**, the CDDP or Brokerage must mail a notice of the assessment process to the individual to be assessed. The notice must include a description and explanation of the assessment process and an explanation of the appeal process

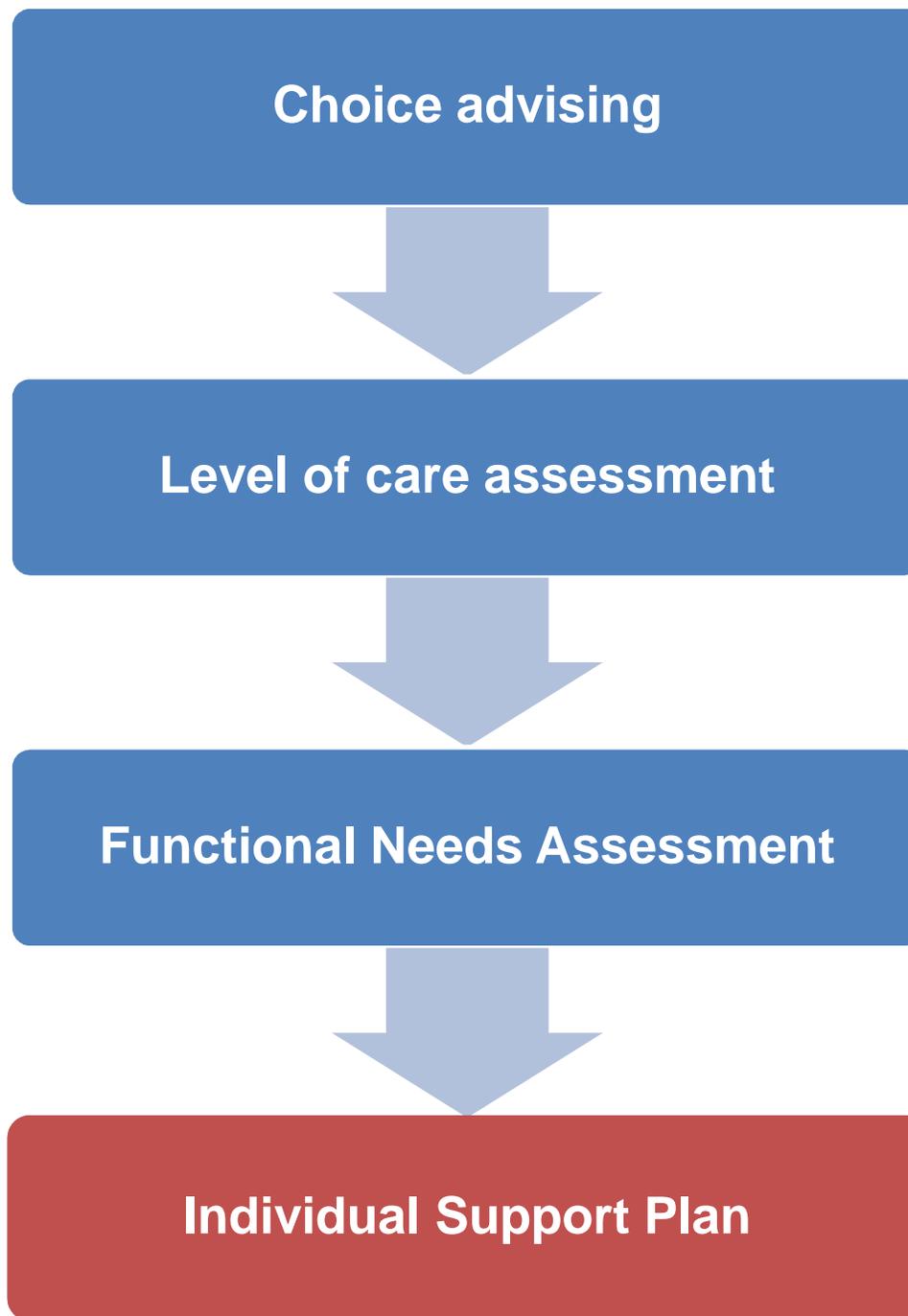
Access to
DD Services

Choice advising

Level of care assessment

Functional Needs Assessment

Individual Support Plan



Individual Support Plan

OAR 411-320-0020

- 61) An ISP includes the written details of the supports, activities, and resources required for an individual to achieve and maintain personal goals and health and safety. The ISP is developed at least annually to reflect decisions and agreements made during a person-centered process of planning and information gathering that is driven by the individual. The ISP reflects services and supports that are important for the individual to meet the needs of the individual identified through a functional needs assessment as well as the preferences of the individual for providers, delivery, and frequency of services and supports. The ISP is the plan of care for Medicaid purposes and reflects whether services are provided through a waiver, the Community First Choice state plan, natural supports, or alternative resources. The ISP includes the Career Development Plan.
- 62) "Individual Support Plan (ISP) Team" means a team composed of an individual receiving services, the legal or designated representative of the individual (as applicable), services coordinator, and others chosen by the individual, such as providers and family members.

ISP – Service Planning

OAR 411-320-0120(4) and 411-340-0120(10)

- Individuals enrolled in waiver or Community First Choice state plan services must have an ISP
- The initial ISP must be authorized:
 - **No more than 90 days from the date a completed application;** or
 - **No later than the end of the month following the month in which the level of care determination was made or no more than 45 days from the date the LOC determination was made.** OAR 411-320-0120(2)(a)
- **Not more than two weeks after authorization,** must provide a copy of the most current ISP to individual or rep
 - OAR 411-320-0120(4)(c)

ISP Reviews – Service Planning

OAR 411-320-0120(9) and 411-340-0120

An ISP must be reviewed and revised:

- **No more than 30 days following a new functional needs assessment;**
- **At least every 12 months;**
- When the circumstances or needs of an individual change significantly; and
- At the request of an individual.

OAR 411-320-0120(10) TRANSITION PLAN REVIEWS. A Transition Plan must be reviewed and updated as necessary to make it consistent with section 4 of the rule **no more than 60 days from the date of entry to a service setting.**

ISP Reviews – Service Planning

- **Upon the request** for a new FNAT by an individual, must revise the ISP for the individual as needed if a revision of the ISP is requested by the individual.
- The revision of the ISP **must be completed within 30 days** from the new FNAT
- The revised ISP must be developed with the individual, the individual's legal or designated representative of the individual (as applicable), and other invited ISP team members.

Annual Plans

OAR 411-320-0120(5) and 411-340-0120(11)

- An Annual Plan must be completed for individuals who do not access waiver or Community First Choice state plan services.
- PA or SC must complete an Annual Plan **within 60 days of entry of an individual into support services, and annually thereafter** if the individual is not enrolled in any waiver or Community First Choice state plan services.
- Must be documented as an Annual Plan or as a comprehensive progress note in the record
 - A review of the current living situation of the individual;
 - A review of any personal health, safety, or behavioral concerns;
 - A summary of the support needs of the individual; and
 - Actions to be taken by the personal agent and others.

Requests for new or increased service

- The individual or designated representative of the individual must either receive a Notification of Planned Action denying the service or have the item authorized in their ISP no later than **45 days from the request date**.
- The following are examples of when either a Notice or a service must be provided to the individual or their designated representative following the request for:
 - a new service,
 - a new provider,
 - an increase in services, or
 - a new needs assessment to be completed

Review Timeline to Access to DD services

Prior to eligibility determination:

1. **Intake = Form + releases of information**
2. **Documents required to make eligibility determination (1-180 days)**
3. **Completed application**
4. **Eligibility determination – Notice within 10 days of completed application**

If eligible, the following applies in this specific order:

5. **Choice advising** prior to (or concurrent with) the LOC assessment
6. **LOC**
7. **FNAT notice 14 days prior FNAT**
8. **FNAT**
 - Not more than **45 days from the date that the individual submitted a completed application**
9. **ISP (waiver or Community First Choice state plan services)**
 - No more than 30 days following a new FNAT
 - No more than **90 days from the date of a completed application**
10. **Annual Plan (not accessing waiver or Community First Choice state plan)**
 - No more than 60 days of enrollment into case management services

Timeline to
Access to
DD Services

