

Medicaid Waiver Services Documentation Requirements

IDD and IFS Waiver Regulations

The following links are the standards governing the eligibility for services for persons enrolled in the Home and Community-Based Services (HCBS) Waivers for Individuals with Intellectual and Developmental Disabilities (IDD) and Individual and Family Supports (IFS), and conditions of participation for professionals and providers of services to receive reimbursement.

IDD Waiver Regulations (Chapter 29-19):

<https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=29-19>

IFS Waiver Regulations (Chapter 29-90):

<https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=29-90&ChapterId=5381>

Individualized Daily Schedules Policy and Procedure

This policy and procedure, and transmittal describe the requirements for daily schedules for people participating in day habilitation or employment readiness services through the Home and Community Based Services (HCBS) waivers, as well as guidance of the requirement in existing District of Columbia regulations for all waiver day services and residential supports settings must create individualized daily schedules for each person receiving supports.

<https://dds.dc.gov/publication/dda-pol001-individualized-daily-schedules-policy-and-procedure>

<https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/DDS%20Transmittal%20%2318-6%20Individualized%20Daily%20Schedules%20Policy%20and%20Procedur...pdf>

Please see the sample schedules for HCBS Waiver services on pages 27-28.

Documentation Requirements for HCBS Waiver Services

Develop an ISP

The ISP includes the following:

- The person interests;
- Specific measurable outcomes for the development of vocational skills, community integration and inclusion that are consistent with the goals based on what is important to and for the person;
- Activities shall be functional.

Progress Notes

Document progress notes for Waiver services, as set forth in each service rule, containing the following information, per 29 DCMR § 1909.2(m) and 29 DCMR § 9006.2(m):

- The progress in meeting the specific goals in the ISP and Plan of Care that are addressed on the day of service and relate to the provider’s scope of service;
- The health or behavioral events or change in status that is not typical to the person;
- Evidence of all community integration and inclusion activities attended by the person and related to the person’s ISP goals and for each, a response to the following questions (DDS recommends the use of the Person-Centered Thinking Learning Log for recording this information):
 - “What did the person like about the activity?”
 - “What did the person not like about the activity?”
- The start time and end time of each shift for any services received including the signature of the Direct Support Professional (DSP) (where progress notes are written using an electronic record system, an electronic signature meets the requirements for signature);
- For services that require awake overnight shifts, the progress notes shall include the support provided as indicated in the specific residential schedule; and
- The matters requiring follow-up on the part of the Waiver service provider or DDS.

File Quarterly Reports

HCBS Waiver providers shall submit quarterly reports to the individual, family/guardian, and Service Coordinator on the programming and support provided to achieve the outcomes in the ISP no later than seven (7) business days after the end of the first quarter, and each subsequent quarter thereafter. The quarterly reports will include the following information (DDS recommends use of the Person-Centered Thinking 4+1 Tool for recording this information, per 29 DCMR §1909.2 (n) and 29 DCMR § 9006.2(n):

- An analysis of the goals identified in the ISP and Plan of Care and monthly progress towards reaching the goals;
- The service interventions provided and the effectiveness of those interventions;
- A summary analysis of all habilitative support activities that occurred during the quarter;
- For providers of Supported Living, Supported Living with Transportation, Host Home Without Transportation, Residential Habilitation, In-Home Supports, Day Habilitation, Individualized Day Supports, and Employment Readiness, the quarter report shall include information on the person’s employment, including place of employment, job title, hours of employment, salary/hourly wage, information on fringe benefits, and current checking, savings and burial fund balances, as applicable;
- Any modifications or recommendations that may be required to be made to the following documents, as described under 29 DCMR §1909.2 (j):
 - The results of the provider’s functional analysis for service delivery;
 - A schedule of the person’s activities in the community, if applicable, including strategies to execute goals identified in the ISP and the date and time of the activity, the staff identified in the staffing plan;
 - Teaching strategies utilized to execute goals in the ISP and the person’s response to the teaching strategy as described in §1909.11 (i.e. the goal statement; the purpose of the goal/measurable outcome; the materials needed to implement the goal; the preferred learning/teaching style for the person; the learning steps; and the method for measuring success); and
 - A support plan with SMARTER goals and outcomes using the information from the DDS approved person-centered thinking and discovery tools, the functional analysis, the ISP, Plan of Care, and other information as appropriate to assist the person in achieving his or her goals.
- For providers of Supported Living, Supported Living with Transportation, Host Home Without Transportation, Residential Habilitation, and High Intensity In-Home Supports, documentation of

the review, implementation, and update, if applicable, of the person’s Health Care Management Plan, in accordance with the DDS Health and Wellness Standards.

Providers should refer to each HCBS Waiver service regulation for specific information that must be included in the quarterly report, specific to the waiver service provided.

Documentation Requirements for Day Services

HCBS Waiver day services include Day Habilitation, Employment Readiness, Individualized Day Supports, and Supported Employment services.

HCBS Waiver day program providers shall develop an annual Positive Personal Profile (PPP) and Job Search and Community Participation Plan for each person receiving day habilitation, individualized day supports, employment readiness and supported employment services. The PPP and Job Search and Community Participation Plan shall be reviewed at least quarterly and updated annually within the ISP year based on what is learned about the person’s needs and interests pertaining to the specific day program service.

Documentation Requirements for Day Habilitation

Day Habilitation Plan

Per 29 DCMR § 1920.13 and 29 DCMR § 9019.13, day habilitation providers must develop a day habilitation plan that corresponds with the person’s Individual Support Plan (ISP) and Plan of Care that supports their interests, choices, goals and prioritizes their needs. In order to develop this plan, the provider must first develop a Positive Personal Profile (PPP) and Job Search and Community Participation Plan. The initial PPP and Job Search and Community Participation Plan must be developed within thirty (30) days of the initiation of services and shall be updated at least annually. Activities in the day habilitation plan shall be functional, chosen by the person, correspond with habilitation needs and provide a pattern of life experiences common to other persons of similar age and the community-at-large. To develop the plan, the provider shall:

- (a) Use observation, conversation, and other interactions, including assessments such as a vocational assessment, as necessary, to develop a functional analysis of the person’s capabilities within the first month of participation and annually thereafter;
- (b) Use the functional analysis, the ISP and Plan of Care, Person-Centered Thinking and Discovery tools, and other information available to identify what is important to and for the person and to develop a plan with measurable outcomes that develops to the extent possible the skills necessary to allow the person to reside and work in the community while maintaining the person’s health and safety; and
- (c) Focus on enabling each person to attain his or her maximum functional level by coordinating Waiver services with other services provided by any licensed professionals listed in the person’s ISP and Plan of Care.

Day Habilitation Schedule

Per 29 DCMR § 1920.14 and 29 DCMR § 9019.14, each provider must develop, with the person, and individualized schedule of daily activities that meets all requirements in the DDS guidance on daily schedules, including that it is based upon the person’s goals and activities as identified in their ISP, and

consistent with what is in their Person-Centered Thinking and Discovery tools, of meaningful adult activities that support the person on their pathway to employment and community integration and inclusion.

Quarterly Reports

Per 29 DCMR § 1920.22 and 20 DCMR § 9019.22, each day habilitation provider must comply with the requirements described under Section 1908 (Reporting Requirements) of Chapter 19 of Title 29 DCMR and Section 1911 (Individual Rights) of Chapter 19 of Title 29 DCMR and Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR. Additionally, quarterly reports shall include a description of the person’s activities in the community that support community integration and inclusion using the Person-Centered Thinking Learning Log, available on-line at: <https://dds.dc.gov/publication/person-centered-thinking-tools-procedure>.

In-Home Day Habilitation

Day Habilitation provider must provide written documentation that in-home services are necessitated by the person’s medical or safety needs.

The Day Habilitation provider is responsible for developing the ISP goals and activities, and the individualized schedule of daily activities. The plan should include transitioning the person to the community to the extent possible.

Documentation Requirement for Employment Readiness Services

Per 29 DCMR § 1922.6 and 29 DCMR § 9022.6, employment readiness providers must develop a Positive Personal Profile (PPP) and Job Search and Community Participation Plan within thirty (30) days of the date when the person began receiving services. An additional vocational assessment, completed by a qualified professional, shall be conducted within the first ninety (90) days of participation, and shall include an assessment of the following:

Vocational Assessment

Vocational assessment within the 90 days of intake and annually. The vocational assessment must include the following:

- (a) Employment-related goals based on a person’s strengths, interests, and areas for improvement;
- (b) Available natural or community supports;
- (c) Personal concerns and preferences, based upon what is important to and for the person;
- (d) Work and career interests based on exploration and/or discovery; and
- (e) Accommodations and supports, including an assessment of assistive technology, which may be required once the person is employed.

The Positive Personal Profile (PPP), Job Search and Community Participation Plan, and additional vocational assessment shall be conducted at least annually by the provider to evaluate each person enrolled in the Waiver’s acquisition of employment-related skills based on the person’s career preferences and goals as specified in their ISP and Plan of Care.

Employment Readiness Plan

Per 29 DCMR § 1922.8 AND 29 DCMR § 9022.8, employment readiness providers must develop an individualized service delivery plan reflecting the person enrolled in the Waiver's interests, career preferences, choices, goals, and prioritized needs. The plan shall:

- (a) Define the specific outcomes to be achieved over a specified period of time;
- (b) Describe the activities in the plan that are developed with the person and support the person in his or her pathway to competitive, integrated employment;
- (c) Describe how the plan shall support a person in the development of employment related skills, including social skills such as interviewing skills, professionalism, building and maintaining relationships, self-determination, and self-advocacy, and attending to the person's needs; and
- (d) Describe community-based employment preparation experiences that are related to the person's employment goals.

Quarterly Reports

Per 29 DCMR § 1922.9 and 29 DCMR § 9022.9, each employment readiness provider must submit reports to Department on Disability Services (DDS) service coordinator on a quarterly basis, consistent with the record maintenance requirements described under Section 1909 (Records and Confidentiality of Information) of Chapter 19 of Title 29 DCMR and Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR. The quarterly reports shall include the following information:

- (a) Volunteer activities provided;
- (b) Employment exploration and/or preparation in the community; and
- (c) Other employment readiness service activities provided.

Employment Readiness Schedule

Per 29 DCMR § 1922.10 and 29 DCMR § 9022.10, each employment readiness provider must develop, with the person, and individualized schedule of daily activities based upon the person's goals and activities as identified in his or her ISP, and consistent with what is in his or her Person-Centered Thinking and Discovery tools, of meaningful adult activities that support the person on his or her pathway to integrated, competitive employment.

Documentation Requirements for Individualized Day Supports

Per 29 DCMR § 1925.3 and 29 DCMR § 9024.3, for individualized day supports services, the person's Individual Support Plan (ISP) and Plan of Care, must document that the need for the service is consistent with the person's assessed needs and personally chosen goals including what is important to and for the person as documented in his or her Person-Centered Thinking and Discovery Tools and recorded in the ISP and Plan of Care, and show at least one of the following:

- (a) That the person chooses to participate in habilitation services in a variety of integrated and inclusive community-based settings which enable to person to attain or maintain his or her maximum functional level and gain greater independence;
- (b) That the person is transitioning into retirement or is retired and chooses to continue habilitation services in a variety of integrated and inclusive community-based settings;

- (c) That the person has person-centered ISP goals for community integration and participation including building, strengthening, and maintaining relationships with persons not paid to be with the person or vocational exploration that may lead to further employment services and supports;
- (d) That the person is likely to be successful in achieving one or more of his or her ISP goals through individualized day supports; or
- (e) That the person has a documented need for individualized day supports due to medical or safety issues that are consistent with the Health Care Management Plan (HCMP) and Behavioral Support Plan.

Individualized Day Supports Plan /Quarterly Reports/Schedules

Per 29 DCMR § 1925.10 and 29 DCMR § 9024.10, each provider approved to provide IDS services must maintain the following records:

- (a) A contingency plan that describes how the IDS will be provided when the primary DSP is unavailable; and, if the lack of immediate support poses a serious threat to the person’s health and welfare, how the support will be provided when back-up DSPs are also unavailable;
- (b) An initial community integration plan, during the first thirty (30) days a person is receiving IDS, utilizing the template required by DDS and containing the following information:
 - (1) The name of the person receiving the service;
 - (2) Service start date;
 - (3) The names of the primary and back-up DSPs that will be delivering the service during the first thirty (30) days of service;
 - (4) The back-up staffing plan if neither the primary or back-up DSPs are available to deliver the service;
 - (5) Goals in the ISP that trigger authorization for individualized day supports;
 - (6) Schedule of service and calendar of activities for the first thirty (30) days;
 - (7) Back-up activities for the first thirty (30) days that relate to the person’s individualized day supports goals and/or exploration and discovery; and
 - (8) Goals to be achieved in the first thirty (30) days of service and methods that will be used to achieve the goals.
- (c) After a person has received IDS for thirty (30) calendar days, an on-going community integration plan utilizing the template required by DDS and containing the following information:
 - (1) The name of the person receiving the services;
 - (2) The names of the primary and back-up DSPs delivering services;
 - (3) The back-up staffing plan if neither the primary or back-up DSPs are available to deliver the service;
 - (4) Goals for the service falling under any of the following categories: Community Membership; Relationships & Natural Supports; Career Exploration & Employment; Retirement (for individuals 61 or older); Community Contribution; Self-Determination; Community Navigation; Wellness/Fitness, or others as listed in the community integration plan template;
 - (5) The highly individualized, integrated community activity/activities or opportunity/opportunities that will support achievement of the goals;
 - (6) Specific skills the person will be assisted to learn that can help with achievement of his/her goals and help the person participate successfully, and as independently as possible, in the Activities/Opportunities;
 - (7) Measurable outcomes promoting community integration which are expected and will indicate the goals have been achieved;

- (8) Calendar of activities for the quarter and back-up activities for the quarter; and
- (9) Teaching objectives, strategies and measurable outcomes for skill development goals;
- (d) Within seven (7) business days of the conclusion of each ISP quarter, submit to DDS Service Coordinator a quarterly report, utilizing the template required by DDS and containing the following information:
 - (1) Description of person’s attendance and participation;
 - (2) Description of person’s relationship with the assigned DSPs;
 - (3) Description of the person’s relationships with others paired with the person to receive the service, if applicable;
 - (4) Description of how the activities and opportunities offered through individualized day supports contribute to the achievement of the person’s service goals;
 - (5) Description of skill development gains and next steps to continue progress on skill development; and
 - (6) Description of career and vocational exploration activities and outcomes for working-age participants in individualized day supports.
- (e) A Positive Personal Profile and Job Search and Community Participation Plan shall be developed annually and reviewed at least quarterly, and that is updated as needed, based upon what is being learned about the person’s needs and interests by the individualized day supports provider. Positive Personal Profile and Job Search and Community Participation Plan shall be used to inform, and attached to, the initial and on-going community integration plans.

Documentation Requirements for Supported Employment

Vocational Assessment

Per 29 DCMR § 1933.29 and 29 DCMR § 9033.29, supported employment providers must complete a comprehensive vocational assessment, at minimum consisting of a Positive Personal Profile and Job Search and Community Participation Plan if the person does not already have a comprehensive assessment. If the person does have a comprehensive vocational assessment, this must be reviewed to ensure it is current and reflects what is important to and for the person and updated as needed.

Per 29 DCMR § 1933.14 and 29 DCMR § 9033.14, each supported employment provider must complete and deliver a comprehensive vocational assessment that includes the following information:

- (a) Employment-related strengths and weaknesses of the person;
- (b) Availability of family and community supports for the person;
- (c) The assessor’s concerns about the health, safety, and wellbeing of the person;
- (d) Accommodations and supports that may be required for the person on the job; and
- (e) If a specific job or entrepreneurial effort has been targeted:
 - (1) Individualized training needed by the person to acquire and maintain skills that are commensurate with the skills of other employees;
 - (2) Anticipated level of interventions that will be required for the person by the job coach;
 - (3) Type of integrated work environment in which the person can potentially succeed; and
 - (4) Activities and supports that are needed to improve the person’s potential for employment, including whether the person has natural supports that may help him or her to be successful in the specific job or entrepreneurial effort.

Supported Employment Plan

Providers must develop a person-centered employment plan that includes the person’s job preferences and desires, through a discovery process and the development of a Positive Personal Profile and Job Search and Community Participation Plan. The individualized employment plan must include training goals and techniques using the template required by DDS and submit it as an attachment to the required quarterly report.

Per 29 DCMR § 1933.30 and 29 DCMR § 9033.30, if extended services are required, the provider must submit a supported employment extension request. The request is a written justification that must be submitted to the Service Coordinator at least fifteen (15) calendar days before the exhaustion of supported employment hours. DDS shall only approve an extension for Job Training and Supports when there is documentation in the employment progress plan that the person continues to demonstrate progress on the job, including but not limited to: learning the job and related tasks, following directions, interaction with others, following supervision, reluctance, or reliance on the job coach, etc. However, if recommended by the person and/or his or her support team and reflected in the ISP, DDS would authorize long-term follow-along supported employment services as needed to support the person on an ongoing basis, per 29 DCMR § 1933.46 and 29 DCMR § 9033.46.

Maintain service records that accurately link the services billed to the ISP/POC.

The documentation includes:

- Person’s name;
- Staff person’s name;
- Date(s) of activities;
- Start and end times of activities;
- Purpose of activities;
- Location of activities;
- Occurrences or behaviors that impede the progress of the group or individual participants;
- Any unusual circumstances or events that impact the stability of the group or individual participant;
- Any incidents; and
- Actions taken to address behaviors or unusual circumstances.

Quarterly Reports

The provider must complete an employment progress plan, using the template required by DDS, and submit it as an attachment to the required quarterly report. Providers are to submit quarterly reports that include the following:

- Person’s name
- Confirmation that wages exceed minimum wage
- Average hours a week worked by each person
- Hours of activities for each person if not engaged in employment
- Aggregate calculation of wages earned, hours worked and hours of activities for person not engaged in employment.

Documentation Requirements for Residential Supports

HCBS Waiver residential supports include Companion, Host Home, In-Home Supports, Personal Care, Residential Habilitation, Supported Living and Respite services.

Documentation Requirements for Companion Services

Companion services must be identified in the person’s ISP, Plan of Care and Summary of Supports, and each person must (1) demonstrate a need for non-medical support and supervision at home or in the community and (2) have the service recommended by the person’s support team, after having considered the appropriateness of the other waiver services and the staffing ratio, if any, in the person’s home.

Companion Service Plan/Quarterly Reports

The companion provider must use the DDS-approved Person-Centered Thinking and Discovery tools to develop a support plan, based upon what has been identified as important to and for the person. For people who receive companion services during waking hours, this should include a flexible list of proposed leisure and recreational activities at home and in the community, based upon the person’s interests. The support plan must be completed within the first week of service, and reviewed and revised quarterly, or more frequently, as needed.

Per 29 DCMR § 1939.13 and 29 DCMR § 9017.13, the service name and provider delivering the services shall be identified in the ISP; the ISP shall document the amount of frequency of services to be received; and the provider shall submit each quarterly review to the person’s DDS Service Coordinator no later than seven (7) business days after the end of the first quarter, and each subsequent quarter thereafter.

Companion Schedule

Each companion services provider must develop, with the person, and individualized schedule of daily activities based upon the person’s goals and activities as identified in his or her ISP, and consistent with what is in his or her Person-Centered Thinking and Discovery tools, of meaningful adult activities. The schedule must include the frequency of services (days and times of the week), outcomes, as documented in the ISP, the person’s interests per their PCT tools, locations of activities in the home and/or community, a key/legend, as applicable, etc. per DDS sample companion schedule.

Documentation Requirements for Host Homes

Functional Analysis

Per 29 DCMR § 1915.5 each host home provider must use Person-Centered Thinking tools and the person’s Positive Personal Profile and Job Search and Community Participation Plan to develop a functional assessment that includes that is important to and for the person, within the first month of the person residing in the host home. This assessment must be reviewed and revised annually or more frequently as needed.

Host Home Plan

Host home provider must develop a program plan with measurable outcomes using the functional analysis/assessment from the Person-Centered Thinking tools, PPP and Job Search and Community Participation Plan, the ISP/POC, and other information as appropriate to enable the person to safely reside in and be integrated as a member of his or her community and aimed at teaching the person to increase his or her skills and self-reliance.

Maintain weekly progress notes or more frequently, as written by the principal care provider, per 29 DCMR § 1915.19(g).

Quarterly Reports

Per 29 DCMR § 1915.5 (e), each host home provider must submit quarterly reports to the person, family and/or guardian, and DDS Service Coordinator no later than seven (7) business days after the end of the first ISP quarter or each subsequent quarter thereafter and in accordance with the requirements described under Section 1908 (Reporting Requirements) and Section 1909 (Records and Confidentiality of Information) of Chapter 19 of Title 29 DCMR.

Documentation Requirements for In-Home Supports

Functional Analysis

In-Home Supports providers must use the DDS-approved Person-Centered Thinking tools, the person’s Positive Personal Profile, and the Job Search and Community Participation Plan to develop a functional assessment that includes what is important to and for the person, within the first thirty (30) calendar days of providing services. This assessment must be reviewed and revised annually or more frequently as needed.

In-Home Supports Plan/Schedule

Per 29 DCMR § 1916.11 and 29 DCMR § 9025.11, an In-Home Supports Plan shall be developed by the provider within thirty (30) days of the start of the service authorization and shall be revised as needed and on an annual basis. The In-Home Supports Plan shall include:

- (a) Activities and supports that will be provided during the service, based on what is important to and for the person, as identified in the Person-Centered Thinking and Discovery tools and reflected in the person’s ISP;
- (b) A staffing plan and schedule;
- (c) A list of licensed, non-medical professionals who will be providing services, if applicable, and
- (d) Emergency contingency plans to address potential behavioral, health or emergency events.

Quarterly Reports

The provider must submit each quarterly review to the person’s DDS Service Coordinator no later than seven (7) business days after the end of the first quarter, and each subsequent quarterly thereafter.

Documentation Requirements for Personal Care

Personal Care services must be ordered, in writing, by a physician or APRN who is enrolled in the DC Medicaid program and has had prior professional relationship with the person that included an examination(s) provided in a hospital, primary care physician's office, nursing facility, or at the person's home prior to the order for personal care services. A written order for personal care services constitutes a certification that the person is unable to perform one (1) or more activities of daily living for which personal care services are needed. The written physician's order for personal care services must be renewed every twelve (12) months. The person must also be authorized for personal care services based on a comprehensive assessment of the person's support needs and risk screening using the DDA Level of Need Assessment and Screening Tool (LON), or its successor, and reflected in the person's Individual Support Plan (ISP) and Plan of Care. The person must first exhaust all available personal care services provided under the Medicaid State Plan prior to receiving personal care services under the Waiver.

Personal Care Plan

The registered nurse must conduct an initial assessment with the person receiving personal care services within seventy two (72) hours of receiving authorization for personal care services from DDS. Per 29 DCMR § 1910.9 and 29 DCMR § 9028.9, the plan of care for the delivery of personal care services shall consist of the following per 5005.2 of Chapter 50 of Title 29 DCMR:

- (a) Be developed by an R.N. in consultation with the beneficiary or the beneficiary's representative based upon the initial face-to-face visit with the beneficiary;
- (b) Specify how the beneficiary's need, as identified in the assessment conducted in accordance with Subsection 5003.3, will be met within the amount, duration, scope, and hours of services authorized by the PCA Service Authorization as set forth in Subsection 5003.4;
- (c) Consider the beneficiary's preference regarding the scheduling of PCA services;
- (d) Specify the detailed services to be provided, their frequency, and duration, and expected outcome(s) of the services rendered consistent with the PCA Service Authorization;
- (e) Be approved and signed by the beneficiary's physician or an APRN within thirty (30) days of the start of care, provided that the physician or APRN has had a prior professional relationship with the beneficiary that included an examination(s) provided in a hospital, primary care physician's office, nursing facility, or at the beneficiary's home prior to the prescription of the PCA service; and
- (f) Incorporate person-centered planning principles that include:
 - (1) Ensuring that the planning process includes individuals chosen by the beneficiary;
 - (2) Ensuring that the planning process incorporates the beneficiary's needs, strengths, preferences, and goals for receiving PCA services;
 - (3) Providing sufficient information to the beneficiary to ensure that he/she can direct the process to the maximum extent possible;
 - (4) Reflecting the beneficiary's cultural considerations and is reflected by providing all information in plain language or consistent with any LEP considerations in accordance with Subsection 5001.3;
 - (5) Strategies for solving conflicts or disagreements; and
 - (6) A method for the beneficiary to request updates to the plan.

The personal care services provider must review the plan of care at least once every sixty (60) days and must update or modify the plan of care as needed. The registered nurse must notify the person's physician of any significant change in the beneficiary's condition. If an update or modification to the plan of care requires any change in the frequency, duration, or scope of personal care services provided to the person, the provider shall obtain an updated authorization for personal care services from DDS in accordance with § 1910.3(d) and § 9028.3(d).

Each provider of personal care services shall develop contingency staffing plans to provide coverage for a person receiving personal care services if the assigned personal care aide cannot provide the service or is terminated by the provider.

Quarterly Reports/Written Documentation

Per 29 DCMR § 1910.16, each personal care services provider shall comply with the record maintenance requirements described under Section 1909 (Records and Confidentiality of Information) of Chapter 19 of Title 29 DCMR, to include progress notes and quarterly reports.

Documentation Requirements Documentation Requirements for Supported Living and Residential Habilitation

Functional Analysis

Supported Living and Residential Habilitation providers must use the Person-Centered Thinking tools, the person's Positive Personal Profile, and the Job Search and Community Participation Plan to develop a functional analysis/assessment that includes what is important to and for the person, within the first month of providing services. This assessment shall be reviewed and revised annually or more frequently as needed.

Supported Living and Residential Habilitation Plans

Supported living and residential habilitation providers must develop program and health support plans with measurable outcomes using the functional analysis/assessment from the Person-Centered Thinking tools, PPP and Job Search and Community Participation Plan, ISP/POC, and other information as appropriate, to develop and maintain skills to remain in the community while maintaining the individual's health and safety.

Maintain a participants attendance roster on a daily basis. Maintain daily progress notes or more frequently.

Progress notes include:

- Progress in meeting each goal in the ISP assigned to the supported living and residential habilitation provider.
- A list of all community activities and the person's response to each activity.
- Any health events, side effects to medication, change in health status, behavioral event, use of restrictive procedures or unusual incidents.
- Each visitor the person receives, special events, and any situation or event requiring follow up.

Maintain current financial records of expenditures.

Quarterly Reports

Supported living and residential habilitation providers must submit quarterly reports to the person, family, as appropriate, guardian, and DDS Service Coordinator in accordance with the requirements described under Section 1908 (Reporting Requirements) and Section 1909 (Records and Confidentiality of Information) of Chapter 19 of Title 29 DCMR.

Documentation Requirements for Respite Services

Respite Daily or hourly services must be authorized by the person’s support team and provided in accordance with the ISP and Plan of Care.

Providers must maintain documentation of the following information:

- Date and amount of time the service is delivered
- Record the activities engaged in
- Person’s response to those activities
- Unusual events or circumstances involving the individual’s health and welfare while respite services were delivered.

Per 29 DCMR § 1930.9 and 29 DCMR§ 9030.9, each respite services provider must comply with the requirements under Section 1908 (Reporting Requirements) and Section 1911 (Individual Rights) of Chapter 19 of Title 29 DCMR, and Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR, except that no quarterly report is required for respite hourly services.

Documentation Requirements for Clinical Services

HCBS Waiver clinical services include Behavioral Supports, Dental, Occupational Therapy, Physical Therapy, Skilled Nursing, and Speech, Language, and Hearing services.

Documentation Requirements for Behavioral Support Services

Behavioral Support Services must be recommended by the person’s support team and/or recommended by a physician or Advanced Practice Registered Nurse (APRN) if the services are one-to-one behavioral supports related to a medical condition, identified in the person’s ISP and Plan Care, and approved by DDS Restrictive Controls Review Committee (RCRC) or Health and Wellness for one-to-one behavioral supports.

Behavioral Support Services providers must complete a diagnostic assessment report (DAR) and the accompanying behavioral support referral worksheet based on the results of the diagnostic assessment. The worksheet accompanying the DAR must include the number of hours requested for professional services, paraprofessional services, and one-to-one behavioral support services to address recommendations in the DAR, per 29 DCMR § 1919.18 and 29 DCMR § 9016.18. The provider must complete the Behavior Support Plan (BSP) when recommended by the DAR.

Per 29 DCMR § 1919.26 and 29 DCMR § 9016.26, the BSP shall include the following:

- (a) A clear description of the targeted behavior(s) that is consistent with the person’s diagnosis;
- (b) The data reflecting the frequency of target behaviors;
- (c) A functional behavioral analysis of each target behavior;
- (d) A description of techniques for gathering information and collecting data;
- (e) The proactive strategies utilized to foster the person’s positive behavioral support;
- (f) The measurable behavioral goals to assess the effectiveness of the BSP;
- (g) If restrictive techniques and procedures are included, the rationale for utilizing the procedures and the development of a fade-out plan; and
- (h) Training requirements for staff and other caregivers to implement the BSP.

Quarterly Reports/Written Documentation

Providers are to complete quarterly reports, diagnostic updates, monitor monthly data, and participate in psychotropic medication review meetings to deliver notes.

Documentation Requirements for Dental Services

Each person must have a documented need for dental services as identified in the Individual Support Plan (ISP) and Plan of Care. Dental services under the IDD Waiver are identical to dental services offered under the District of Columbia’s Medicaid State Plan and shall be provided in accordance with the applicable requirements set forth in Section 964 (Dental Services) of Chapter 9 of Title 29 DCMR.

Dental Plan

Per 29 DCMR § 1921.5, each provider of Medicaid reimbursable dental services shall develop a written treatment plan for the person receiving dental services after completion of a comprehensive evaluation. The services provided shall be consistent with the treatment plan.

Per 29 DCMR§ 1921.6, the treatment plan shall be updated annually and shall serve as a guide for treatment to be completed over the course of one (1) year unless special circumstances require a longer treatment plan.

Documentation Requirements for Occupational Therapy

Occupational Therapy services must be ordered by a physician, as evident in the annual medical evaluation/physical examination report/documentation or by physician’s order and must be updated annually (every 12 months). The service must be identified as a need and documented in the person’s ISP and Plan of Care and include the service name and provider entity delivering services, service intensity, frequency, and duration must be determined by the person’s individual need.

Occupational Therapy Plan

The therapy plan must include therapeutic techniques, training goals for the person’s caregiver, schedule for ongoing services, and the anticipated and measurable functional outcomes based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP, per 29 DCMR § 1926.5 and 29 DCMR 9026.5.

Quarterly Reports/Written Documentation

Per 29 DCMR § 1926.7 and 29 DCMR § 9026.7, occupational therapy shall consist of the following activities:

- (a) Consulting with the person, their family, caregivers and support team to develop the therapy plan;
- (b) Implementing therapies described under the therapy plan;
- (c) Recording progress notes and quarterly reports during each visit. Progress notes shall contain the following:
 - (1) Progress in meeting each goal in the ISP;
 - (2) Any unusual health or behavioral events or changes in status;
 - (3) The start and end time of any services received by the person; and
 - (4) Any matter requiring follow-up on the part of the service provider or DDS;
- (d) Routinely assessing (at least annually and more frequently as needed) the appropriateness, quality and functioning of adaptive equipment to ensure it addresses the person’s needs;

- (e) Completing documentation required to obtain or repair adaptive equipment in accordance with insurance guidelines and Medicare and Medicaid guidelines, including required timelines for submission;
- (f) Participating in ISP and Support Team meetings to provide consultative services and recommendations specific to the expert content with a focus on how the person is doing in achieving the functional goals that are important to him or her; and
- (g) Conducting periodic examinations and modified treatments for the person, as needed.

Documentation Requirements for Physical Therapy

Physical Therapy services must be ordered by a physician, physician’s assistant, or nurse practitioner’s order, as evident in the annual medical evaluation/physical examination report/documentation and must be updated annually (every 12 months). The service must be identified as a need and documented in the person’s ISP and Plan of Care and include the service name and provider entity delivering services, scope of physical therapy services, frequency, and duration must be determined by the person’s individual needs.

Physical Therapy Plan

Per 29 DCMR § 1928.5 and 29 DCMR § 9029.5, the therapy plan shall include therapeutic training techniques, training goals for the person’s caregiver, and a schedule for ongoing services. The therapy plan shall include the anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP and a schedule of approved physical therapy services to be provided, and shall be submitted by the Medicaid provider to DDS before services are delivered.

Quarterly Reports/Written Documentation

Per 29 DCMR § 1928.7 and 29 DCMR § 9029.7, physical therapy services shall consist of the following activities:

- (a) Consulting with the person, their family, caregivers, and support team to develop the therapy plan;
- (b) Implementing therapies described under the therapy plan;
- (c) Recording progress notes on each visit and submitting quarterly reports. Progress notes shall contain the following:
 - (1) Progress in meeting each goal in the ISP;
 - (2) Any unusual health or behavioral events or changes in status;
 - (3) The start and end time of any services received by the person; and
 - (4) Any matter requiring follow-up on the part of the service provider or DDS;
- (d) Routinely assessing (at least annually and more frequently as needed) the appropriateness, quality and functioning of adaptive equipment to ensure it addresses the person’s needs;
- (e) Completing documentation required to obtain or repair adaptive equipment in accordance with insurance guidelines and Medicare and Medicaid guidelines, including required timelines for submission; and
- (f) Conducting periodic examinations and modified treatments for the person, as needed.

Each individual providing physical therapy services shall participate in ISP and Support Team meetings to provide consultative services and recommendations specific to the expert content with a focus on how the person is doing in achieving the functional goals that are important to him or her.

Documentation Requirements for Skilled Nursing

Skilled Nursing services must be ordered by a physician, as evident in the annual medical evaluation/physical examination report/documentation or by physician's order, when it is reasonable and necessary to the treatment of the person's illness and injury, and include a letter of medical necessity, a summary of the person's medical history and the duties that the skilled nurse would perform and a skilled nurse checklist. The physician's order must include the scope, frequency, and duration of skilled nursing services, and must be updated at least every sixty (60) calendar days. A Prior Authorization Form- 719A from the Department of Health Care Finances will suffice as the physician's order in accordance with the requirements in DCMR § 1931 and DCMR § 9031. The person must first exhaust all available skilled nursing visits provided under the Medicaid State Plan prior to receiving skilled nursing services under the Waiver.

The service must be identified as a need and documented in the person's ISP and Plan of Care and include the service name and provider entity delivering services, scope, frequency, and duration of skilled nursing services, and must be updated at least every sixty (60) calendar days and maintained in the person's records.

Skilled Nursing Plan

The service must be identified as a need in the person's ISP and Plan of Care and include the service name and provider entity delivering services, scope, frequency, and duration of skilled nursing services, and must be updated at least every sixty (60) calendar days and maintained in the person's records.

Per 29 DCMR § 1931.17 and 29 DCMR § 9031.17, the skilled nursing provider shall maintain a contingency plan that describes how skilled nursing will be provided when the scheduled nurse is unavailable; and, if the lack of immediate care poses a serious threat to the person's health and welfare, how the service will be provided when back-up staff are unavailable.

Quarterly Reports/Written Documentation

Per 29 DCMR § 1931.7(i) and 29 DCMR § 9031.7(i), recording progress notes during each visit that meet the standards of nursing care and include the following:

- (1) Any unusual health or behavioral events or changes in status;
- (2) Any matter requiring follow-up on the part of the service provider or DDS; and
- (3) Clearly written records that contain a statement of the person's progress or lack of progress, medication conditions, functional losses, and treatment goals that demonstrate that the person's services are and continue to be reasonable and necessary.

Skilled nursing providers must submit summary notes at least quarterly and submit quarterly reports.

Documentation Requirements for Speech, Language and Hearing

Speech, Language and Hearing services must be ordered by a physician and must be updated annually (every 12 months), as evident in the annual medical evaluation/physical examination report/documentation or by physician's order, if the person has a medically-related condition such as a history or aspiration, swallowing problems, tube feeding, or a tracheotomy, or recommended by the support team, if the person has a non-medical condition such as a receptive or expressive speech delay or disorder that is reasonable and necessary to treat the person's medical or non-medical communicative disorder. The service must be identified as a need and documented in the person's ISP and Plan of Care

and include the service name and provider entity delivering services, frequency, and duration must be determined by the person's individual needs.

Speech, Hearing and Language Service Plan

Per 29 DCMR § 1932.5 and 29 DCMR § 9032.5, each individual providing speech, hearing and language services shall comply with the following service delivery requirements:

- (a) Conduct a comprehensive assessment, within the first (4) hours of service delivery, which shall include the following:
 - (1) A background review and current functional review of communication capabilities in different environments;
 - (2) An environmental review of communication in places of employment, residence, and other sites as necessary;
 - (3) The potential for use of augmentative and alternative speech devices, methods, or strategies;
 - (4) The potential for sign language or other expressive communication methods; and
 - (5) A needs assessment for the use of adaptive eating equipment.
- (b) Develop and implement a speech, hearing and language treatment plan, within the first four (4) hours of service delivery, that describes treatment strategies, including direct therapy, training of caregivers, monitoring requirements and instructions, and the anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP;
- (c) Assist persons with voice disorders to develop proper control of vocal and respiratory systems for correct voice production, if applicable;
- (d) Conduct aural rehabilitation by teaching sign language and lip reading to people who have hearing loss, if applicable;
- (e) Participate in ISP and Support Team meetings to provide consultative services and recommendations specific to the expert content with a focus on how the person is doing in achieving the functional goals that are important to him or her;
- (f) Record progress notes on each visit and submit quarterly reports;
- (g) Verify that the speech, hearing, and language assessment and treatment plan, and daily notes and quarterly reports, are delivered to the person, family or caregiver, physician, and the Department on Disability Services (DDS) Service Coordinator prior to the person's Support Team meeting;
- (h) Assess the need for the use of adaptive equipment;
- (i) Routinely assess (at least annually and more frequently as needed) the appropriateness and quality of adaptive equipment to ensure it addresses the person's needs;
- (j) Conduct periodic examinations to modify treatments, as appropriate, for the person receiving services and ensure that the speech pathologist's or audiologist's recommendations are incorporated into the ISP; when necessary; and
- (k) Complete documentation required to obtain or repair adaptive equipment in accordance with insurance requirements and Medicare and Medicaid guidelines, including required timelines for submission.

Quarterly Reports/Written Documentation

Daily progress notes must contain the person's progress in meeting each goal in the ISP, any unusual health or behavioral events or changes in status, the start and end time of any services received by the person, and any matter requiring follow-up on the part of the service provider or DDS.

Providers must submit quarterly reports to include the functioning of the person’s adaptive equipment, as applicable.

Documentation Requirements for Professional Services

HCBS Waiver professional services include Creative Arts Therapies, Education Supports (*IFS Waiver only*), Family Training, and Parenting Support services.

Documentation Requirements for Creative Arts Therapies

Creative Arts Therapies include art, dance drama, and music therapy. Creative Arts Therapies must be ordered by a physician or a practitioner, as evident in the annual medical evaluation/physical examination report/documentation or by physician’s order and must be updated annually (every 12 months), or recommended by the support team, if it reasonable and necessary for the treatment of social and emotional difficulties related to a number of mental health issues including disability, illness, trauma, loss, and physical and cognitive problems. The service must be identified as a need and documented in the person’s ISP and Plan of Care and include the service name and provider entity delivering services, frequency, and duration must be determined by the person’s individual needs.

Creative Arts Therapies Plan/Written Documentation/Quarterly Reports

Per 29 DCMR § 1918.6 and 29 DCMR § 9018.6, each person providing Creative Arts Therapies service shall:

- (a) Conduct an assessment within in the first two (2) hours of delivering the service;
- (b) Develop and implement an individualized art, dance, drama, or music plan for the person that is in keeping with their choices, goals and prioritized needs that includes the following:
 - (1) Treatment strategies including direct therapy, caregiver training, monitoring requirements and instructions, and anticipated outcomes; and
 - (2) Identification of specific anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP.
- (c) Deliver the completed plan to the person, family, guardian or other caregiver, and the Department on Disability Services (DDS) Service Coordinator prior to the Support Team meeting;
- (d) Participate in the ISP and Support Team meetings, when invited by the person, to provide consultative services and recommendations specific to the expert content with the focus on how the person is doing in achieving the functional goals that are important to him or her;
- (e) Provide necessary information to the individual, family, guardian or caregivers, and/or team, to assist in planning and implementing the approved ISP and Plan of Care;
- (f) Record progress notes on each visit;
- (g) Submit quarterly reports in accordance with the requirements in Section 1909 (Records and Confidentiality of Information) of Chapter 19 of Title 29 DCMR and Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR;
- (h) Conduct periodic examinations and modify treatments for the person receiving services as necessary; and
- (i) Meet all of the requirements in Section 1906 (Requirements for Direct Support Professionals) of Chapter 19 of Title 29 DCMR and Section 9011 (Requirements for Direct Support Professionals) of Chapter 90 of Title 29 DCMR.

Documentation Requirements for Education Supports

Each provider of education supports services, in the Individual and Family Supports (IFS) Waiver, must first obtain a written Service Authorization from DDS before providing education supports services. DDS will not be responsible for the payment of any post-secondary educational institution costs that the person may incur before receiving DDS’s written commitment to fund the eligible costs at the post-secondary educational institution. The ISP, Plan of Care, and Summary of Supports and Services must document the amount and frequency of services to be received.

Education Supports Plan/Documentation

Per 29 DCMR § 9021.2, education supports services will be authorized when:

- (a) The person requests the service or is recommended by the person’s support team;
- (b) The person has a demonstrated need for the service to enhance or maintain independence; to increase, maintain, or improve education; or to support increased community inclusion;
- (c) The person has an employment outcome or outcome-related goals for skill attainment or development that is documented in the service plan and is related to the need for education supports services;
- (d) Education supports services is included in the person’s ISP and Plan of Care;
- (e) The person demonstrates that previous application for Rehabilitation Services Administration (RSA) funded post-secondary education was made, by the submission of a letter documenting either ineligibility for RSA services or documenting that the person has fully utilized services available under related services as defined in Sections 602(9) and 602(26) of the Individuals with Disabilities Education Act (20 U.S.C. §§ 1400 *et seq.*);
- (f) The person submits a financial aid application annually to the following:
 - (1) The post-secondary institution the individual is attending or to which the individual has applied;
 - (2) The D.C. Tuition Assistance Grant, if applicable;
 - (3) All other District or state funded educational assistance programs and school grants or financial aid;
 - (4) The U.S. Department of Education (The Free Application for Federal Student Aid (FAFSA));
 - (5) All federal grant programs, including the Pell Grant; and
 - (6) The Leverage Educational Assistance Program (LEAP);
- (g) The person provides DDA with a copy of the FAFSA Student Aid Report (SAR) and any other aid award from each source; and
- (h) The person signs DDA’s form authorizing the post-secondary institution to provide DDA with information relating to the person’s training or educational program, including, but not limited to:
 - (1) A copy of the person’s official transcript;
 - (2) A copy of the person’s grades at the conclusion of each quarter or semester;
 - (3) Attendance records;
 - (4) Financial awards;
 - (5) Notice of any disciplinary or adverse action; and
 - (6) A copy of the person’s Americans with Disabilities Act (ADA) accommodation plan.

Documentation Requirements for Family Training

Family Training Plan/Schedule

Family training services professionals must conduct an assessment of family training needs within the first four (4) hours of service delivery and develop a training plan with training goals and techniques that will assist the person’s unpaid caregivers. The training plan must include the person’s need for additional uncompensated support, the family training service professional who will provide the family training services, the person’s caregivers who will receive the family training services, measurable outcomes and a schedule of approved family training services to be provided.

The following information must be documents in the person’s ISP and Plan of Care for family training services:

- (a) The date and amount of family training services provided;
- (b) The nature of the family training services provided;
- (c) The professional who provided the family training services; and
- (d) The individual caregivers who received the family training services.

Per 29 DCMR § 1924.7 and 29 DCMR § 9023.7, family training services shall include the following activities:

- (a) Instruction about treatment regimens and other services included in the person’s ISP and Plan of Care;
- (b) Instruction on the use of equipment specified in the person’s ISP and Plan of Care;
- (c) Counseling aimed at assisting the unpaid caregiver in meeting the needs of the person; and
- (d) Follow up training necessary to safely maintain the person at home.

Quarterly Reports/Written Documentation

Per 29 DCMR § 1924.11(c) and 29 DCMR § 9023.11(c), each family training provider shall maintain the documents required under Section 1909 (Records and Confidentiality and Information) of Chapter 19 of Title 29 of the DCMR and Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 of the DCMR, to include progress notes and quarterly reports for monitoring and audit reviews.

Documentation Requirements for Parenting Support

Per 29 DCMR 1942.3 and 29 DCMR § 9027.3, Parenting Support will be authorized when:

- (a) The person is an expectant parent, a parent with physical custody or visitation with his or her child, or a parent who pursuing reunification with his or her child;
- (b) The person requests the service and/or it is recommended by the person’s support team; and
- (c) Parenting support services are included in the person’s Individual Support Plan (ISP) and Plan of Care.

Parenting Support Plan

Per 29 DCMR 1942.4 and 29 DCMR § 9027.4, each parenting support services provider shall comply with the following service delivery requirements:

- (a) Conduct an assessment, within the first four (4) hours of service delivery, which shall include the following:

- (1) A background review and current functional review of the person’s parenting capabilities in different environments;
- (2) An environmental review in the person’s home, and other community site as necessary; and
- (b) Develop and implement a parenting support plan, within the first four (4) hours of service delivery, that describes strategies, and the anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP and Plan of Care.

Quarterly Reports/Written Documentation

Per 29 DCMR § 1942.8(c) and 29 DCMR § 9027.8(c), each parenting supports services provider shall maintain the documents required under Section 1909 (Records and Confidentiality and Information) of Chapter 19 of Title 29 of the DCMR and Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR, to include progress notes and quarterly reports for monitoring and audit reviews.

Documentation Requirements for Wellness Services

HCBS Waiver wellness services include Bereavement Counseling, Fitness Training, Massage Therapy, Nutrition Evaluation/Consultation, and Sexuality Education services.

Per 29 DCMR § 1936.11 and 29 DCMR § 9034.11, each professional providing wellness services must:

- (a) Conduct an initial assessment within the first four (4) hours of service delivery with long term and short term goals;
- (b) Develop and implement a person-centered plan consistent with the person’s choices, goals and prioritized needs that describes wellness strategies and the anticipated and measurable functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP. The plan shall include treatment strategies including direct therapy, caregiver training, monitoring requirements and instructions, and specific outcomes;
- (c) Deliver the completed plan to the person, family, guardian, residential provider, or other caregiver, and the DDS Service Coordinator prior to the Support Team meeting;
- (d) Participate in the ISP and Support Team meetings, when invited by the person, to provide consultative services and recommendations specific to the wellness professional’s area of expertise with the focus on how the person is doing in achieving the functional goals that are important to him or her;
- (e) Provide necessary information to the person, family, guardian, residential provider, or other caregivers and assist in planning and implementing the approved ISP and Plan of Care;
- (f) Record progress notes on each visit which contain the following:
 - (1) The person’s progress in meeting each goal in the ISP;
 - (2) Any unusual health or behavioral events or change in status;
 - (3) The start and end time of any services received by the person; and
 - (4) Any matter requiring follow-up on the part of the service provider or DDS.
- (g) Submit quarterly reports in accordance with the requirements in Section 1909 (Records and Confidentiality of Information) of Chapter 19 of Title 29 DCMR and Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR; and
- (h) Conduct periodic examinations and modify treatments for the person receiving services, as necessary.

Documentation Requirements for Bereavement Counseling

Bereavement Counseling services must be requested by the person and/or recommended by the person’s support team and must have experienced a loss through death, relocation, change in family structure, or loss of employment. The service must be identified as a need in the person’s ISP and Plan of Care and include the service name and provider entity delivering services, service intensity, frequency, and duration must be determined by the person’s individual needs and documented in the person’s ISP and Plan of Care.

Documentation Requirements for Fitness Training

Fitness training services must be ordered by a physician, as evident in the annual medical evaluation/physical examination report/documentation or by physician’s order and must be updated annually (every 12 months). The service must be identified as a need in the person’s ISP and Plan of Care and include the service name and provider entity delivering services, service intensity, frequency, and duration must be determined by the person’s individual needs and documented in the person’s ISP and Plan of Care.

Documentation Requirements for Massage Therapy

Massage Therapy services must be ordered by a physician, as evident in the annual medical evaluation/physical examination report/documentation or by physician’s order and must be updated annually (every 12 months). The service must be identified as a need in the person’s ISP and Plan of Care and include the service name and provider entity delivering services, service intensity, frequency, and duration must be determined by the person’s individual needs and documented in the person’s ISP and Plan of Care.

Documentation Requirements for Nutrition Evaluation/Consultation

Nutrition Evaluation/Consultation services must be ordered by a physician, as evident in the annual medical evaluation/physical examination report/documentation or by physician’s order and must be updated annually (every 12 months). The service must be identified as a need in the person’s ISP and Plan of Care and include the service name and provider entity delivering services, service intensity, frequency, and duration must be determined by the person’s individual needs and documented in the person’s ISP and Plan of Care.

Per 29 DCMR § 1936.12 and 29 DCMR § 9034.12, each professional providing nutrition evaluation/consultation services must comply with the additional requirements, as needed:

- (a) Conduct a comprehensive nutritional assessment within the first four (4) hours of delivering the services;
- (b) Conduct a partial nutritional evaluation to include an anthropometric assessment;
- (c) Perform a biochemical or clinical dietary appraisal;
- (d) Analyze food-drug interaction potential, including allergies;
- (e) Perform a health and safety environmental review of food preparation and storage areas;
- (f) Assess the need for a therapeutic diet that includes an altered/textured diet due to oral-motor problems;
- (g) Conduct a needs assessment for adaptive eating equipment and dysphagia management;
- (h) Conduct a nutrition evaluation and provide consulting services on a variety of subjects, including recommendations for the use of adaptive equipment, to promote improved health and increase the

person's ability to manage his or her own diet or that of his or her child(ren) in an effective manner; and

- (i) Provide education to include menu development, shopping, food preparation, food storage, and food preparation procedures consistent with the physician's orders.

Documentation Requirement for Sexuality Education

Sexuality Education services must be requested by the person and/or recommended by the person's support team. The service must be identified as a need in the person's ISP and Plan of Care and include the service name and provider entity delivering services, service intensity, frequency, and duration must be determined by the person's individual needs and documented in the person's ISP and Plan of Care.

Documentation Requirements for Assistive Technology

Per 29 DCMR § 1941.6 and 29 DCMR § 9015.3, a person qualifies for assistive technology services when he or she requests the service and/or it is recommended by the person's support team to enhance or maintain the person's independence, increase, maintain, or improve functional capabilities, and/or support increased community inclusion; or there is a physician's order for the service. Assistive technology services must be included in the person's Individual Support Plan (ISP) and Plan of Care.

Assistive Technology Plan

Per 29 DCMR § 1941.7 and 29 DCMR § 9015.4, each professional providing assistive technology services shall:

- (a) Conduct a comprehensive assessment within the first four (4) hours of service delivery, which shall include the following:
 - (1) A background review and current functional review of the person's capabilities in different environments;
 - (2) An environmental review in places of employment, residence, and other sites as necessary; and
 - (3) A needs assessment for the use of assistive technology.
- (b) Develop and implement an assistive technology plan within the first four (4) hours of service delivery that describes strategies, including recommended assistive technology goods, coordination with professional services, training of caregivers, monitoring requirements and instructions, and the anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP and Plan of Care.

Quarterly Reports/Written Documentation

Per 29 DCMR § 1941.12 and 29 DCMR § 9015.9, each assistive technology services provider shall maintain the following documents for monitoring and audit reviews:

- (a) A Copy of the assistive technology assessment and treatment plan;
- (b) A copy of the physician's order, if applicable;
- (c) A copy of receipts documenting the date, item, amount expended, and any related warranty; and
- (d) Any other applicable documents required to be maintained under Section 1909 (Records and Confidentiality and Information) of Chapter 19 of Title 29 of the DCMR and Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR, where applicable.

Documentation Requirements for Remote Supports Services

Remote Supports Services (RSS) delivery is available to the following HCBS IDD and IFS Waiver services:

- (a) Behavioral Supports**
- (b) Bereavement Counseling**
- (c) Creative Arts Therapies**
- (d) Day Habilitation**
- (e) Employment Readiness**
- (f) Family Training**
- (g) Fitness Training**
- (h) Nutrition Evaluation/Consultation**
- (i) Occupational Therapy**
- (j) Parenting Supports**
- (k) Sexuality Education**
- (l) Speech, Hearing and Language**
- (m) Supported Living (Daily and Periodic) (IDD Waiver only)**

The support team will utilize the Assessing Interest in Remote Supports and Technology tool to assess the person’s ability to benefit at different levels/hours of RSS engagement to determine how many hours the person can engage in this service delivery for the appropriate waiver service(s). A hybrid model will be used for in-person and remote supports service hours where two service authorizations will be issued to cover the in-person service hours and the remote support service hours, as waiver services cannot be delivered remotely one hundred percent (100%) of the time and has a requirement for in-person visits.

Remote Supports Services Plan/Written Documentation/Quarterly Reports

Required remote support content in the ISP must include the following:

- (a) Justification statement that explains how remote supports benefits the person, promotes independence, assists in outcome achievement, assures health and safety, etc. Also, justify the need for any other services such as the need for Assistive Technology services for the purposes to acquire equipment rental/purchase;
- (b) Description of the person’s personal preferences and how the delivery of remote supports will reflect them. This should reflect the utilization of person-centered tools and exhibit how support strategies have been developed to meet the summarized preferences.
- (c) Verification that a risk assessment was completed and reviewed through the utilization of the person’s person-centered tools and other assessment results by the support team to ensure the appropriate technology solutions and/or support strategies have been identified to address any risk areas;
- (d) Description of the required remote support equipment function, purpose, features, general location in home, person and family knowledge of and how to use equipment (e.g. turn on and off, how to request assistance remotely, etc.);
- (e) Description of initial and ongoing training strategies for person supported, support staff, and family members, if applicable;
- (f) Schedule when remote supports will be provided and type of remote supports (e.g., Active Support, Active On-Demand, Check-in Scheduled, Check-in Random) provided;
- (g) Detailed back-up plan description in the event of system failure (e.g., equipment malfunction, power outage). Detailed emergency/on-call responder plan in the event the person needs a paid

in-person response to their residence. The emergency response plan can include natural supports or paid supports. The detailed plan for response at the person’s residence or location covered by remote supports should include at a minimum a description of:

- (1) Response time as per requirements defined by the team. In situations requiring a person to respond to person’s residence, the response time should not exceed “30 minutes”;
- (2) Response type includes face-to-face and/or telephone, depending on how to optimally respond to the person supported particular need at that time to ensure health and safety;
- (3) In emergency situations, the remote support vendor and/or caregiver shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities; and
- (4) Documentation of the event as outlined in DDS Incident Management Policy.

Service and provider documentation for supported living through remote supports shall include each of the following to validate payment for Medicaid services:

- (a) Type of service;
- (b) Date of service;
- (c) Place of service;
- (d) The use of Remote Supports must be documented appropriately, just like any in-person direct supports, and identify the service delivery method of service (e.g. two-way, real-time interactive video-audio communication or audio-only communication);
- (e) Start and end time of service;
- (f) Name of individual receiving service;
- (g) Medicaid identification number of individual receiving service;
- (h) Name of provider;
- (i) Name of staff person providing service;
- (j) Begin and end time of the remote support service when the backup on-call support person is needed on site;
- (k) Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are in file with the provider;
- (l) Number of units of the delivered service per calendar day;
- (m) Description and details of the services delivered that directly relate to the services specified in the approved Individual Support Plan (ISP) as the service to be provided;
- (n) Notes to verify service provision during the shift/day/hourly/units in which service delivery in accordance with Section 1909 (Records and Confidentiality of Information), Subsections 1909.1-1909.12, of Chapter 19 of Title 29 DCMR, and Section 9006 (Records and Confidentiality of Information), Subsections 9006.1- 9006.13 of Chapter 90 of Title 29 DCMR, as applicable to the HCBS waiver the person is enrolled;
- (o) If, for example, a sensor alerts the remote caregiver staff, describe the occurrence that activated the sensor, when it happened, who was involved, response, and outcome;
- (p) Description of any communication between remote caregiver staff and person supported;
- (q) Staff attendance logs with staff initials for the time segments each was directly involved in providing remote supports during that time frame, if applicable;
- (r) Provider quarterly report; and
- (s) Complete any incident reports as applicable to DDS Incident Management Policy.

Service and provider documentation for all other HCBS Waiver services through remote supports shall include each of the following to validate payment for Medicaid services:

- (a) Type of service;
- (b) Date of service;

- (c) Place of service;
- (d) The use of Remote Supports must be documented appropriately, just like any in-person direct supports, and identify the service delivery method of service (e.g. two-way, real-time interactive video-audio communication or audio-only communication);
- (e) Start and end time of service;
- (f) Name of individual receiving service;
- (g) Medicaid identification number of individual receiving service;
- (h) Name of provider;
- (i) Name of staff person providing service;
- (j) Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are in file with the provider;
- (k) Number of units of the delivered service per calendar day;
- (l) Description and details of the services delivered that directly relate to the services specified in the approved Individual Support Plan (ISP) as the service to be provided;
- (m) Notes to verify service provision during the shift/day/hourly/units in which service delivery in accordance with Section 1909 (Records and Confidentiality of Information), Subsections 1909.1-1909.12, of Chapter 19 of Title 29 DCMR, and Section 9006 (Records and Confidentiality of Information), Subsections 9006.1- 9006.13 of Chapter 90 of Title 29 DCMR, as applicable to the HCBS waiver the person is enrolled;
- (n) Description of any communication between remote caregiver staff and person supported;
- (o) Staff attendance logs with staff initials for the time segments each was directly involved in providing remote supports during that time frame, if applicable;
- (p) Provider quarterly report; and
- (q) Complete any incident reports as applicable to DDS Incident Management Policy.

Sample Schedules for HCBS Waiver Residential and Day Services

NAME:JOHN DOE		PROVIDER:ABC			
INTERESTS	GOALS				
CARS:A	Goal 1. Mr. John Doe will participate in fitness class.				
ANIMALS:B	Goal 2: Mr. John Doe will be able to navigate around his community walking and utilizing the metrobus/rail system in a safe manner.				
MUSIC:C	Goal 3: Community Inclusion: Mr. Doe will join and participate in a community group (s)				
COOKING:D	Goal 4. Employment: Mr. Doe will Volunteer in the community				
	Goal 5: Employment: Mr. Doe will improve my communication to increase success seeking employment/interviews				
	Goal 6: MONEY MANAGEMENT: Mr. Doe will make at least 5 independent purchases per week				
	MONDAY (IDS)	TUESDAY(DAY HAB)	WEDNESDAY (IDS)	THURSDAY((DAY HAB)	FRIDAY(IDS)
9:00a.m.	Metro/Train (2) [SB]	Transitional activities :COFFEE and Greeting people as they come in introducing himself (5)[SB]	Walk to Animal shelter to Volunteer:(ADDRESS) (1, 2,B) [SB]	Transitional activities :COFFEE and Greeting people as they come in introducing himself (5)[SB]	Walk to neighborhood pool;(ADDRESS) (1, 2,) [SB]
10:00a.m.	Music Jazz History Club at Smithsonian (address)Washington DC (3, C)	Operating a computer: EXPLORING interests BY DESIGNING A CAR, A [SB]	Volunteer at Animal Shelter (4, B) [SB]	Small group: Walk in neighborhood, allowing group members to direct route(2) [SB]	Participate in Water Aerobic set to music (1, C) [SB]
11:00a.m.	Music Jazz History Club at Smithsonian (address)Washington DC (3, C)	Group Healthy Cooking Class: (1,D) [SB]	Volunteer at Animal Shelter (4, B) [SB]	Discussion group: Post walk recalling what Mr. Doe saw, retracing the route, discussion the weather that day. (2,5)	Pool leisure (1)
12:00p.m.	Lunch: nearby Subway restaurant (address)(1,2,5,6) [SB]	Lunch	Walk to nearby restaurant to get lunch then walk to HYDE Park(address) (1,6) [SB]	Work Benefit Group: discussion on benefits of work	Walk to nearby restaurant to get lunch then walk to HYDE Park (ADDRESS) (1,6) [SB]
1:00 p.m.	Walk to Metrorail Purchase ticket (1,2,6) [SB]	Group Drumming (C,)	Lunch: Hyde Park listen to Jazz in the Park (2,C)	Lunch	Lunch time concert Hyde Park (C)
2:00p.m.	Central Library, (address)CHECK out book on an interest (A/B/C/D)	Small group: Walk in neighborhood, (route) identify various traffic signs (2) [SB]	Walk to Metro rail Purchase ticket (1,2,6) [SB]	Work Benefit Group: How to fill out a job application with support ;each week a variety of samples offered. (SB)	TRAVELING via Metro to Model Car Group (address). Petworth (2, 3) [SB]
3:00pm	Walk home:(address) (1, 2) [SB]	Group Car Club in ABC (A)	Walk from Metrorail stopping at book store(address) to BROWSE/PURCHASE car magazine then home(A,1,2,6) [SB]	Communication skills group: mock interview with unfamiliar and describe what he wants and why he should be hired (5)[SB]	Meeting with group members Car Model Group (ADDRESS) (2, 3) [SB]
GREEN = TIME IN THE COMMUNITY		SB =SKILL BUILDING (supports the pathway to community integration and employment)			
DAY HAB LOCATION		GOALS=NUMERIC (1,2,3,....)		INTERESTS=ALPHABETIC: (A,B,C,D...)	

MEDICAID WAIVER SERVICES DOCUMENTATION REQUIREMENTS- FEBRUARY 2024

**ABC DAY SERVICES
COMPANION ACTIVITY SCHEDULE**

Person: JOHN DOE Residence: 123 MY HOME WAY, WASHINGTON DC 20003

ISP YEAR: 1/15/2021- 1/14/2022 Companion Services: M-F 9 a.m.- 2 p.m.

Outcomes	1. John will improve his health through exercise.	
	2. John will improve his independent living skills.	
	3. John will engage in entertainment activities.	
Interests	A. Exercise: yoga, stationary bike, push-ups, cardio	F. Taking out the trash
	B. Movies, reality TV shows, cooking shows, podcasts	G. Having a clean home (wash dishes, sweep, mop)
	C. Cooking/Prep meals	H. Computers
	D. Doing laundry	
	E. Listening to music (R&B, hip hop)	
Locations	L1. Gold's Gym - 1000 Workout Way, Forestville, MD	
	L2. Home - 123 My Home Way, WDC 20003	

KEY: 1, 2, 3- Outcomes
A-H - Interests
L1, L2- Locations

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
9:00am	He will choose which activity he wants to engage in daily. 3B or 3E/HL2	He will choose which activity he wants to engage in daily. 3B or 3E/HL2	He will choose which activity he wants to engage in daily. 3B or 3E/HL2	He will choose which activity he wants to engage in daily. 3B or 3E/HL2	He will choose which activity he wants to engage in daily. 3B or 3E/HL2
10:00am	1A L1 or L2	1A L1 or L2	1A L1 or L2	1A L1 or L2	1A L1 or L2
11:00am	2C L2	2C L2	2C L2	2C L2 2D L2	2C L2
12:00pm	Eat lunch	Eat lunch	Eat lunch	Eat lunch	Eat lunch
1:00pm	2G L2	2G L2	2G L2	2G L2	2G L2
2:00pm	3B or 3E/HL2	3B or 3E/HL2	3B or 3E/HL2	2F 3B or 3E/HL2	3B or 3E/HL2