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CHAPTER 411
DEPARTMENT OF HUMAN SERVICES
AGING AND PEOPLE WITH DISABILITIES AND DEVELOPMENTAL DISABILITIES

FILING CAPTION: ODDS: Children's Extraordinary Needs Program (411-415, 435, 440, 450)

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RULES:
411-415-0020, 411-415-0030, 411-415-0040, 411-415-0070, 411-415-0080, 411-415-0090, 411-435-0030, 411-435-0060, 411-440-0010, 411-440-0020, 411-440-0030, 411-440-0040, 411-440-0050, 411-440-0060, 411-440-0070, 411-440-0080, 411-440-0090, 411-450-0020, 411-450-0030, 411-450-0060, 411-450-0080

AMEND: 411-415-0020

REPEAL: Temporary 411-415-0020 from APD 25-2024

RULE TITLE: Definitions and Acronyms for Case Management Services

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-415-0020 about definitions and acronyms for case management services is being amended to:

- Include definitions for the Children's Extraordinary Needs Program and definitions specifically about case management services previously found in OAR 411-317-0000.
- Improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:
In addition to the following definitions, OAR 411-317-0000 includes general definitions for words and terms frequently used in OAR chapter 411, division 415. If a word or term is defined differently in OAR 411-317-0000, the definition in this rule applies.
(1) "ADL" means "Activities of Daily Living" as defined in OAR 411-317-0000.
(2) "Affiliated Entity" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), or a political subdivision or instrumentality (including a municipal corporation of a state), that has an incident of ownership in a case management entity. For the purposes of this definition:
(a) "Incident of Ownership" means an ownership interest, an indirect ownership interest, or a combination of direct and indirect ownership interests.
(b) "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in another

entity. Indirect ownership interest includes an ownership interest in an entity that has an indirect ownership interest in another entity.
(c) "Ownership Interest" means the possession of equity in the capital, stock, or profits of an entity.
(3) "Case Management Contact" means a reciprocal interaction between a case manager and an individual or the individual's legal or designated representative (as applicable).
(4) "Case Management Services" mean the functions performed by a case manager that are funded by the Department. Case management services include, but are not limited to, the following:
(a) Assessment of support needs.
(b) Developing an Individual Support Plan or Annual Plan that may include authorized services.
(c) Information and referral for services.
(d) Monitoring the effectiveness of services and supports.
(5) "Case Manager" means a person who delivers case management services or person-centered service planning for and with individuals, meets the qualifications in OAR 411-450-0040, and is employed as one of the following:
(a) A personal agent by a Brokerage.
(b) A services coordinator by a Community Developmental Disabilities Program.
(c) A services coordinator by the Department.
(6) "CDDP" means "Community Developmental Disabilities Program" as defined in OAR 411-317-0000 and described in OAR chapter 411, division 320.
(7) "Children's Extraordinary Needs (CEN) Program" is defined in OAR 411-440-0020 and described in OAR chapter 411, division 440.
(8) "Choice Advising" means the unbiased sharing of information with an individual about case management entities, providers, services, or setting options by a representative of a case management entity. Choice advising is delivered:
(a) Using language, format, and presentation methods appropriate for effective communication; and
(b) According to the needs and abilities of the individual receiving services and the people important in supporting the individual.
(9) "CIIS" means "Children's Intensive In-Home Services" as defined in OAR 411-317-0000 and described in OAR chapter 411, division 300.
(10) "Client Child" is defined in OAR 411-440-0020 for the Children's Extraordinary Needs Program.
(11) "CME" means "Case Management Entity" as defined in OAR 411-317-0000. A CME includes the following:
(a) A Community Developmental Disabilities Program.
(b) A Brokerage.
(c) CIIS.
(d) The Children's Residential Program of the Department.
(12) "County of Origin" is defined in OAR 411-320-0020.
(13) "Geographic Service Area" means the area within Oregon where a case management entity is approved to provide developmental disabilities services. The geographic service area for a Community Developmental Disabilities Program is the county.
(14) "IADL" means "Instrumental Activities of Daily Living" as defined in OAR 411-317-0000.
(15) "ICF/IID Level of Care" means institutional level of care for an intermediate care facility for individuals with intellectual disabilities. ICF/IID Level of Care is further defined in OAR 411-317-0000.
(16) "IEP" means "Individualized Education Program" as defined in OAR 411-317-0000.
(17) "Initial ISP" means the first Individual Support Plan:
(a) For an individual who is newly entered into case management services; or
(b) Following a period when an individual did not have an authorized Individual Support Plan.
(18) "Initial Level of Care" means the first level of care determination:
(a) For an individual who is newly accessing Community First Choice (K Plan) or 1915(c) waiver services; or
(b) Following a period when an individual was not determined to meet level of care.

(19) "Initial ONA" means the first Oregon Needs Assessment:
(a) For an individual who is newly accessing Community First Choice (K Plan) or waiver services; or
(b) Following a period when an individual did not have a current Oregon Needs Assessment.
(20) "ISP" means "Individual Support Plan" as defined in OAR 411-317-0000.
(21) "Level of Care" includes "ICF/IID Level of Care", "Hospital Level of Care", or "Nursing Facility Level of Care", as defined in OAR 411-317-0000.
(22) "OHP" means "Oregon Health Plan" as defined in OAR 410-120-0000.
(23) "ONA" means "Oregon Needs Assessment" as defined in OAR 411-317-0000 and described in OAR 411-425-0055.
(24) "Parent Provider" is defined in OAR 411-440-0020 for the Children's Extraordinary Needs Program.
(25) "SSI" means "Supplemental Security Income" as defined in OAR 411-317-0000.
(26) "These Rules" mean the rules in OAR chapter 411, division 415.
(27) "Transition Period" means the first 60 calendar days after an individual enters a new program type, setting, or case management entity.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.105, 427.115, 427.154, 427.191, 430.212, 430.662, 430.731

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.005-427.154, 427.191, 430.212, 430.215, 430.610, 430.620, 430.662, 430.664, 430.731-430.768

AMEND: 411-415-0030

REPEAL: Temporary 411-415-0030 from APD 25-2024

RULE TITLE: Eligibility for Case Management Services - Entry, Exit, Transfers

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-415-0030 about eligibility for case management services - entry, exit, transfers is being amended to:

- Reflect how case management services will be provided to children enrolled in the Children's Extraordinary Needs Program.
- Improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

(1) An individual may not be denied case management services or otherwise discriminated against on the basis of race, color, religion, sex, gender identity, sexual orientation, national origin, marital status, age, disability, source of income, duration of Oregon residence, or other protected classes under federal and Oregon Civil Rights laws.

(2) To be eligible for case management services, an individual must be determined eligible for developmental disabilities services by the CDDP of the county of origin as described in OAR 411-320-0080.

(a) An adult who is eligible for case management services who lives in their own home or family home may select to have case management services provided by a CDDP or a Brokerage, when the Brokerage has the capacity to provide the service according to OAR 411-340-0110. When a local Brokerage is selected, but the local Brokerage does not have the capacity to provide case management, case management must be delivered by the local CDDP until the local Brokerage has capacity.

(b) A child or adult selecting services from a residential program may only have case management services delivered by a CDDP or the Department.

(c) A child who is eligible for and receives family support services, according to OAR chapter 411, division 305, may only have case management services delivered by a CDDP.

(d) A child who is eligible for and enrolled in a CIIS program, according to OAR chapter 411, division 300, may only have case management services delivered by the Department and the CDDP, with respective roles identified in the ISP.

(e) A child enrolled to the Children's Extraordinary Needs Program who meets ICF/IID Level of Care and has an intellectual disability or other developmental disability must be enrolled to a CDDP for case management services.

(3) To be eligible for case management services delivered by a CIIS services coordinator, a child must:

(a) Meet the eligibility requirements for a CIIS program in OAR 411-300-0120 and be enrolled to the program; or

(b) Be enrolled in the Children's Extraordinary Needs Program, according to OAR chapter 411, division 440, and:

(A) Meet the Nursing Facility Level of Care or the Hospital Level of Care, as defined in OAR 411-317-0000; and

(B) Not meet the ICF/IID Level of Care as defined in OAR 411-317-0000.

(4) In order to receive case management services, an individual, or as applicable the individual's legal representative, must accept all of the following supports:

(a) Assistance from a case management entity with the design and management of Department-funded services and supports.

(b) Abuse investigations.

(c) The presence of a case manager at required entry or exit meetings.

(d) Monitoring of services (when applicable) in accordance with OAR 411-415-0090.

(e) Case management contacts as described in OAR 411-415-0090.

(f) Case manager access to the individual's service record.

(5) ENTRY INTO CASE MANAGEMENT.

(a) The county of origin must enter an individual who is eligible for developmental disabilities services into case management services.

(b) Upon entry into case management services, a case management entity must provide an explanation of the individual

rights described in OAR 411-318-0010 to an individual and if applicable the individual's legal representative.
(c) A case management entity must assure the availability of a case manager to address the support needs of each individual and during any emergency or crisis.
(d) A case management entity must appropriately document the assignment of a case manager in an individual's service record and accurately report the individual's entry into case management services in the Department's electronic payment and reporting system.
(A) Within 10 business days from an individual's date of entry, a case management entity must send a written notice to the individual, and as applicable the individual's legal representative, that includes the name, telephone number, and location of the case manager assigned to the individual.
(B) A case management entity must ask an individual, and as applicable the individual's legal representative, to identify any family and other advocates to whom the case manager's name, telephone number, and location must be provided.
(6) EXIT FROM CASE MANAGEMENT.
(a) A case management entity retains responsibility for providing case management services to an individual until the responsibility is terminated and the individual exits from case management services as described in this rule.
(b) A case management entity must exit an individual from case management services when any of the following occur:
(A) The individual, or as applicable the individual's legal representative, submits a signed written request terminating case management services, or such a request is made by telephone and documented in the individual's service record.
(B) The individual dies.
(C) The individual is determined to be ineligible for:
(i) Developmental disabilities services in accordance with OAR 411-320-0080; or
(ii) CIIS in accordance with OAR chapter 411, division 300.
(D) The individual is not a resident of Oregon.
(E) The individual moves out of the geographic service area of the case management entity. If an individual takes up residence in another geographic service area, a case management entity that operates in the new geographic service area may enter the individual into case management services.
(i) If an individual receiving case management from a CDDP moves to a new geographic service area, the original CDDP may continue to provide case management services to the individual. The individual, or as applicable the individual's legal or designated representative, must request to retain case management services from the original CDDP, and both the original CDDP and the CDDP in the new location must agree in writing to the responsibilities for delivering case management services.
(ii) If an adult individual receiving case management from a Brokerage moves to a new geographic service area, the Brokerage may continue to provide case management services. The adult individual, or as applicable the individual's legal or designated representative, must request to retain case management services from the original Brokerage, and the Department must approve. Approval may be granted if the Brokerage is available to meet the case management standards described in OAR 411-415-0050 timely and adequately and the Brokerage has the capacity to deliver the case management services.
(iii) In the case of a child moving into a foster home, host home, or 24-hour residential program, the county of parental residency or court jurisdiction must retain responsibility for case management services unless:
(I) The child is entering into a state operated group home; or
(II) An agreement between the CDDPs and the child's legal representative is reached that describes the responsibilities for case management services.
(F) After the individual either cannot be located or has not responded after a minimum of 30 calendar days of repeated attempts by a case management entity to complete ISP development, Annual Plan development, or monitoring activities.
(G) After the individual has been incarcerated, hospitalized, or in a nursing facility, for longer than 12 consecutive months.
(c) An exit from case management services is an exit from all developmental disabilities services, except when an

individual moves within Oregon but out of the geographic service area of their case management entity.
(d) When an individual is being exited from case management services, the case management entity must issue a Notification of Planned Action consistent with OAR 411-318-0020 to notify the individual, and as applicable the individual's legal representative, of the case management entity's intent to terminate case management services and any other developmental disabilities services. A Notification of Planned Action is not required when the exit from case management is due to:
(A) The individual's death; or
(B) The individual moves within Oregon but out of the geographic service area of the case management entity.
(e) When a child is exited from a CIIS program or the CEN Program, the child may remain enrolled at the CDDP for case management services if the child is eligible for developmental disabilities services according to OAR 411-320-0080.
(7) CHANGE OF CASE MANAGEMENT SERVICES PROVIDER.
(a) An available case management entity, chosen by an individual, or as applicable the individual's legal or designated representative, must enter an eligible individual into the case management entity within 10 calendar days from the request to change case management entities, unless a later date is mutually agreed upon by the individual, or as applicable the individual's legal or designated representative, and the case management entities involved in the change. The agreement must be documented in an individual's service record by the case management entity of the individual at the time of the agreement.
(b) A change in case management entity may only be to a CDDP or Brokerage that is within the same geographic service area as the individual's residence, unless an exception is approved by the Department.
(c) The exiting case management entity must assure all relevant information is provided to the entering case management entity to assist the entering case management entity in implementing an ISP or Annual Plan that best meets the individual's support needs including, but not limited to all of the following:
(A) A current application on the Department-mandated application.
(B) A copy of the Level of Care determination, if present.
(C) A copy of the current functional needs assessment, if present or if unavailable in the Department’s electronic payment and reporting system.
(D) A copy of eligibility determination and records used to make the determination.
(E) Copies of financial eligibility information.
(F) Copies of any legal documents, such as documents about guardianship, conservatorship, civil commitment status, probation, or parole.
(G) Copies of progress notes.
(H) A copy of the current ISP or Annual Plan and any protocols, Service Agreements, Functional Behavior Assessments, Behavior Support Plans, and Nursing Service Plans.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.105, 427.115, 427.154, 427.191, 430.212, 430.662, 430.731

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.005-427.154, 427.191, 430.212, 430.215, 430.610, 430.620, 430.662, 430.664, 430.731-430.768

AMEND: 411-415-0040

REPEAL: Temporary 411-415-0040 from APD 25-2024

RULE TITLE: Case Manager Staff Requirements

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-415-0040 about case manager staff requirements is being amended to:

- Include training requirements for case managers prior to a case manager authorizing services for the Children's Extraordinary Needs Program.
- Improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

(1) CASE MANAGER QUALIFICATIONS. A case manager must have knowledge of the public service system for developmental disabilities services in Oregon and at least one of the following:

(a) A bachelor's degree in behavioral science, social science, or a closely related field.

(b) A bachelor's degree in any field and one year of human services related experience, such as work providing assistance to people and groups with economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing.

(c) An associate's degree in a behavioral science, social science, or a closely related field and two years of human services related experience, such as work providing assistance to people and groups with economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing.

(d) Three years of human services related experience, such as work providing assistance to people and groups with economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing.

(2) CASE MANAGER TRAINING. A case manager must participate in a core competency training sequence approved by the Department. The core competency training sequence is not a substitute for the normal procedural orientation that a case management entity must provide to a new case manager.

(a) The orientation provided by a case management entity to a new case manager must include all of the following:

(A) An overview of the case manager's role and responsibilities.

(B) An overview of developmental disabilities services and related human services within the geographic service area of the case management entity.

(C) An overview of the Department's rules governing the case management entity.

(D) An overview of the Department's rules, policies, and Expenditure Guidelines for services and providers that may be authorized by the case management entity.

(E) An overview of the enrollment process and required documents needed for enrollment into the Department's electronic payment and reporting system.

(F) A review and orientation of Medicaid, Supplemental Security Income, Social Security Administration, home and community-based waiver and state plan services, the medical assistance programs delivered by the Oregon Health Authority, and the individual support planning processes for the services the case manager coordinates.

(G) A review (prior to having contact with individuals) of the case manager's responsibility as a mandatory reporter of abuse, including abuse of individuals with intellectual or developmental disabilities, individuals with mental illness, older adults, individuals with physical disabilities, and children.

(b) A case manager must participate in an on-line series of required case management core competency modules as follows:

(A) A case manager hired after January 1, 2017 must complete:

(i) Tier 1 trainings within 30 calendar days from the date of employment and before working unassisted.

(ii) Tier 2 trainings within 90 calendar days from the date of employment.

(B) Other case managers must complete core competency modules as directed by the Department.

(c) Within the first year, a case manager must attend or participate in ISP training that is endorsed or sponsored by the Department.
(d) A case manager must continue to enhance their knowledge, as well as maintain a basic understanding of developmental disabilities services, self-determination, person-centered thinking and practices, and the skills, knowledge, and responsibilities necessary to perform the duties of their position. A case manager must participate in a minimum of 20 hours per year of Department sponsored training or other training in the areas of intellectual or developmental disabilities, equity and diversity, mental health, or substance abuse.
(e) Prior to authorizing services for the Children's Extraordinary Needs Program in a client child's ISP, a case manager must complete the Department's training about:
(A) How to support families to manage issues concerning conflicts of interest.
(B) Provider recruitment and retention strategies.
(C) How to empower a client child to have a meaningful voice in the selection of the client child's direct support professionals.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.105, 427.115, 427.154, 427.191, 430.212, 430.662, 430.731

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.005-427.154, 427.191, 430.212, 430.215, 430.610, 430.620, 430.662, 430.664, 430.731-430.768

AMEND: 411-415-0070

REPEAL: Temporary 411-415-0070 from APD 25-2024

RULE TITLE: Service Planning for Developmental Disabilities Services

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-415-0070 about service planning for developmental disabilities services is being amended to include the Children's Extraordinary Needs Program and improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

This rule prescribes standards for the development and implementation of an Individual Support Plan (ISP) or Annual Plan.

(1) An ISP must meet the following requirements:

(a) Be developed using a person-centered planning process consistent with OAR 411-004-0030 and in a manner that addresses issues of independence, integration, and provides opportunities to seek employment and work in competitive integrated employment settings, in order to assist with establishing outcomes, planning for supports, and reviewing and redesigning support strategies.

(b) Be designed to enhance an individual's quality of life.

(c) Be consistent with the following principles:

(A) Adult individuals have the right to make informed choices about the level of family member participation.

(B) The preferences of an individual, and when applicable a child's legal representative or family, must serve to guide the ISP team. A case manager must facilitate active participation of an individual throughout the planning process.

(C) The planning process is designed to identify the types of services and supports necessary to achieve an individual's preferences, and when applicable a child's legal representative or family, identify the barriers to providing those preferred services, and develop strategies for reducing the barriers.

(D) Specify cost-effective arrangements for obtaining the required supports and applying public, private, formal, and alternative resources available to an eligible individual.

(E) When planning for a child in a 24-hour residential program, foster home, or host home, the following must apply:

(i) Unless contraindicated, there must be a goal for family reunification.

(ii) The number of moves or transfers must be kept to a minimum.

(iii) Unless contraindicated, if the placement of a child is distant from their family, the child's case manager must continue to seek a placement that brings the child closer to their family.

(d) Be developed based on assessed need.

(e) For community living supports, the ISP must include an hour allocation that is within:

(A) The maximum service level for an individual as described in OAR 411-450-0060(7)(f) or (h); or

(B) The amount approved by an exception as described in OAR 411-450-0065.

(2) An individual enrolled in waiver or Community First Choice (K Plan) services must have an ISP, completed on a Department approved document, consistent with the outcome of the person-centered planning process and OAR 411-004-0030.

(a) An initial ISP may begin a transition period as defined in OAR 411-415-0020. During a transition period, the ISP must include the minimum necessary services and supports for an individual upon entry to a new program type, setting, or case management entity. The ISP during a transition period must include, at a minimum, the following:

(A) An authorization of necessary services.

(B) The supports needed to facilitate adjustment to the services offered.

(C) The supports necessary to ensure health and safety.

(D) The assessments and consultations necessary for further ISP development.

(b) An initial ISP has a duration of 12 full months, beginning the month following the authorization of the ISP and ending at the end of the 12th month.

(c) The duration of an annual ISP is 12 months. With an individual's consent, or as applicable the consent of the individual's legal or designated representative, a start date for an initial ISP may be established within the 12 months when the individual enters or exits any of the following:
(A) A 24-hour residential program as described in OAR chapter 411, division 325. A transfer to a new setting within the same 24-hour residential program may not cause a new start date for an ISP.
(B) A host home program as described in OAR chapter 411, division 348. A transfer to a new setting within the same host home program may not cause a new start date for an ISP.
(C) A supported living program as described in OAR chapter 411, division 328. A transfer to a new setting within the same supported living program may not cause a new start date for an ISP.
(D) Foster care as described in OAR chapter 411, division 346 for children or OAR chapter 411, division 360 for adults.
(E) A CIIS program.
(d) All Department-funded developmental disabilities services included in an ISP must be consistent with the ISP manual, Department policy, and the Expenditure Guidelines, when applicable.
(e) For Community First Choice (K Plan) and waiver services, the supports included in an ISP must reflect the services and supports that are important for an individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.
(3) INDIVIDUALLY-BASED LIMITATIONS.
(a) An initial or annual ISP for an individual receiving services in a residential setting must include any applicable individually-based limitations to the following freedoms:
(A) Support and freedom to access the individual’s personal food at any time.
(B) Visitors of the individual's choosing at any time.
(C) A lock on the individual's bedroom, lockable by the individual.
(D) Choice of a roommate, if sharing a bedroom.
(E) Freedom to furnish and decorate the individual's bedroom as the individual chooses in accordance with a Residency Agreement.
(F) Freedom and support to control the individual's schedule and activities.
(b) An individually-based limitation must be in accordance with OAR 411-004-0040 and be supported by an individual's specific assessed need due to threats to the health and safety of the individual or others.
(c) An initial or annual ISP for an individual receiving services in any setting must include any applicable individually-based limitations to the individual’s freedom from restraint.
(d) An individually-based limitation must only include a safeguarding intervention that:
(A) Meets the definition found in OAR 411-317-0000 and complies with OAR 411-304-0150, OAR 411-304-0160, and applicable program rules.
(B) When used to address a challenging behavior, is directed in a Positive Behavior Support Plan written by a behavior professional qualified to author the safeguarding intervention according to ODDS-approved behavior intervention curriculum and certification as described in OAR 411-304-0150.
(C) When used to address a medical condition or medical support need, is included in a medical order written by an individual's licensed health care provider. The medical order may only indicate the use of a safeguarding intervention to address a medical condition and must include all of the following:
(i) The medical need for the use of the safeguarding intervention.
(ii) Situations for when to use the safeguarding intervention.
(iii) The length of time or situations permitted for the use of the safeguarding intervention.
(e) An individually-based limitation must only include safeguarding equipment that:
(A) Meets the definition found in OAR 411-317-0000 and complies with OAR 411-304-0150 and applicable program rules.
(B) When used to address a challenging behavior, is directed in a Positive Behavior Support Plan written by a behavior

professional as described in OAR 411-304-0150.
(C) When used to address a medical condition or medical support need, is included in a medical order written by an individual's licensed health care provider. The medical order may only indicate the use of safeguarding equipment to address a medical condition and must include all of the following:
(i) The medical condition the safeguarding equipment addresses.
(ii) The type of safeguarding equipment.
(iii) Situations for when to use the safeguarding equipment.
(iv) The length of time or situations permitted for the use of the safeguarding equipment.
(4) TEMPORARY EMERGENCY SAFETY PLAN. A Temporary Emergency Safety Plan described in OAR 411-304-0150 may be in effect for up to 90 calendar days. The date may be extended up to an additional 90 calendar days with approval from an individual and the individual's case manager to allow additional time for the completion of a Functional Behavior Assessment and Positive Behavior Support Plan.
(5) CAREER DEVELOPMENT PLAN.
(a) A Career Development Plan must be completed as part of an ISP:
(A) When an individual is working age; or
(B) Prior to the expected exit from school for students eligible for services under the Individuals with Disabilities Education Act (IDEA). If a student leaves school prior to the expected exit, the student must have the opportunity to have a Career Development Plan within one year of the unexpected exit.
(b) A Career Development Plan must meet the following requirements:
(A) For an individual who uses employment services as described in OAR chapter 411, division 345, include goals and objectives related to obtaining, maintaining, or advancing in competitive integrated employment, or at minimum, exploring competitive integrated employment or developing skills that may be used in competitive integrated employment.
(B) Be developed based on a presumption that, with the right support and job match, an individual may succeed and advance in an integrated employment setting and earn minimum wage or better.
(C) Prioritize competitive integrated employment in the general workforce.
(D) For an individual who has competitive integrated employment, person-centered planning must focus on maintaining employment, maximizing the number of hours the individual works consistent with their preferences and interests, improving wages and benefits, and promoting additional career or advancement opportunities.
(E) For an individual using job coaching or job development services, document either a goal or discussion regarding opportunities for maximizing work hours and other career advancement opportunities. The recommended standard for planning job coaching and job development is the opportunity to work at least 20 hours per week. Individualized planning should ultimately be based on individual choice, preferences, and circumstances, and recognize that an individual may choose to pursue working full-time, part-time, or another goal identified by the individual.
(F) Document all employment service options presented, including the option to use employment services in a non-disability specific setting, meaning a setting that is not owned, operated, or controlled by a provider of home and community-based services.
(G) For an individual who uses employment services in a sheltered workshop setting, document the individual has been encouraged to choose a community-based employment service option and not a sheltered workshop setting option.
(6) ISP REVIEWS.
(a) An ISP must be reviewed, and as needed, revised and re-authorized:
(A) No later than the end of the month following the month in which the Oregon Needs Assessment was conducted.
(B) Prior to the expiration of the ISP.
(C) No later than the end of a transition period.
(D) When the circumstances or needs of an individual change significantly.
(E) At the request of an individual or as applicable the individual's legal or designated representative.
(b) For an individual who changes case management entities, but remains in an in-home setting, the ISP authorized by

the previous case management entity may be used as authorization for available services when the services in the new setting remain appropriate.
(7) TEAM PROCESS IN PERSON-CENTERED PLANNING. This section applies to an ISP developed for an individual receiving services in a residential program.
(a) The ISP is developed by the individual, the individual's legal or designated representative (as applicable), and the services coordinator. Others may be included as a part of the ISP team at the invitation of the individual and as applicable the individual's legal or designated representative. In order to assure adequate planning, provider representatives are necessary informants to the ISP team even when not ISP team members.
(b) In circumstances where an individual is unable to express their opinion or choice using words, behaviors, or other means of communication and the individual does not have a legal or designated representative, the following apply:
(A) On behalf of the individual, the ISP team is empowered to make a decision the ISP team feels best meets the health, safety, and assessed needs of the individual.
(B) Consensus amongst ISP team members is prioritized. When consensus may not be reached, majority agreement is used. For purposes of reaching a majority agreement each interested party, which may be represented by more than one person, is considered as one member of the ISP team. Interested parties may include, but are not limited to, the individual's provider, family, and services coordinator.
(C) No one member of an ISP team has the authority to make decisions for the ISP team.
(c) Any objections to the decisions of an ISP team by a member of the ISP team must be documented in the ISP.
(d) A services coordinator must track the ISP timelines and coordinate the resolution of complaints and conflicts arising from ISP discussions.
(8) ISP AUTHORIZATION.
(a) An initial and annual ISP must be authorized prior to implementation.
(b) Unless noted otherwise in these or program rules, an initial ISP must include the Medicaid funded developmental disabilities services for which an individual is eligible and desires. An initial ISP must be authorized no more than 90 calendar days from the date of the request for the services when the individual making the request is enrolled in a Medicaid Title XIX benefit package or a benefit package through Healthier Oregon. A completed application, as defined in OAR 411-320-0020, and submitted to the CDDP, is a request for services if the individual is enrolled in a Medicaid Title XIX benefit package or a benefit package through Healthier Oregon at the time the completed application is submitted.
(c) A revision to an initial or annual ISP that begins or ends a developmental disabilities service paid using Department funds must be authorized prior to implementation.
(d) A revision to an initial or annual ISP that does not begin or end a developmental disabilities service paid using Department funds does not require authorization. The case management entity must provide written notification of the revision to the individual, or as applicable their legal or designated representative, prior to implementation of the revision.
(e) An initial ISP, and a revision to an initial or annual ISP requiring authorization, is authorized on the date:
(A) The signature of the individual, or as applicable the individual's legal or designated representative, is present on the ISP, or documentation is present explaining the reason an individual who does not have a legal or designated representative may be unable to sign the ISP.
(i) Acceptable reasons for an individual without a legal or designated representative not to sign the ISP include physical or behavioral inability to sign the ISP.
(ii) Unavailability is not an acceptable reason for an individual, or as applicable the individual's legal or designated representative, not to sign the ISP.
(iii) Documented oral agreement may substitute for a signature for up to 10 business days when a revision to an initial or annual ISP is in response to an immediate, unexpected change in circumstance, and the revision is necessary to prevent injury or harm to the individual.
(B) The signature of the case manager involved in the development of, or revision to, the ISP is present on the ISP.

(f) A renewing ISP signed as described in this section, is authorized to begin the first calendar day after the previous ISP expired.
(g) All authorized developmental disabilities services funded through the Community First Choice (K Plan) or home and community-based services waivers must occur in a setting consistent with OAR 411-004-0020.
(h) Community First Choice (K Plan) and waiver services are only funded by the Department when the services are authorized in an ISP developed in a manner consistent with this rule.
(i) A legal or designated representative responsible for directing the development of an ISP on behalf of an individual (as applicable) may not be authorized to be a paid provider for the individual.
(j) An ISP may only have services authorized for personal support workers when the services are consistent with the payment limitations described in OAR 411-375-0040.
(k) An hour allocation or staffing ratio that requires approval from the Department may not be included in an authorized ISP prior to the date of the approval unless there is an imminent threat to an individual's health and safety that may be mitigated by additional supports. A request for the Department to approve additional supports intended to mitigate an imminent threat to an individual's health and safety must be submitted to the Department by a case management entity within five calendar days of the authorization of the additional supports.
(l) An ISP for an adult enrolled in a foster home, as described in OAR chapter 411, division 360, must include at least six hours of activities each week that are of interest to the individual that do not include television or movies made available by the provider. Activities are those available in the community and made available or offered by the provider or the CDDP.
(A) Activities may include the following:
(i) Recreational and leisure activities.
(ii) Other activities required to meet the needs of an individual as described in the individual's ISP.
(B) Activities that contribute to the six hours may not include any of the following:
(i) Rehabilitation.
(ii) Educational services.
(iii) Employment services.
(m) Not more than two weeks after authorization, a case management entity must provide a copy of an individual's most current ISP to the individual, the individual's legal and designated representative (as applicable), and others as identified by the individual.
(A) An ISP must be made available using language, format, and presentation methods appropriate for effective communication and according to the needs and abilities of the individual receiving services and the people important in supporting the individual.
(B) When an authorized ISP must be translated from English, translation must be initiated within two weeks of authorization and the translated document must be provided to the individual by the case management entity upon receipt.
(n) A case manager may not knowingly authorize a community living supports agency or a standard model agency to utilize an agency employee to deliver community living supports skills training or attendant care services, other than day support activities as defined in OAR 411-450-0020, to an individual that also engages the same person for services as the individual's personal support worker.
(9) DEVELOPMENTAL DISABILITIES SERVICE AUTHORIZATION LIMITS.
(a) Developmental disabilities services may not be authorized or must be terminated in the following circumstances:
(A) An individual does not meet the service eligibility requirements in the program rule corresponding to the service.
(B) A case manager is not permitted to conduct a monitoring visit to an individual's home, as required in OAR 411-415-0090, if services are expected to occur in the home.
(C) An individual fails to participate in, or be available for, the conducting of the components of an Oregon Needs Assessment within the timeframes identified in OAR 411-415-0060.
(b) A case management entity may deny, or must terminate, services from a provider, services in a setting, or a

combination of services, selected by an eligible individual or the individual's legal or designated representative in the following circumstances:
(A) The setting has dangerous conditions that jeopardize the individual's health or safety and necessary safeguards are not available to improve the setting.
(B) Services may not be provided safely or adequately by the provider based on:
(i) The extent of the individual's service needs; or
(ii) The choices or preferences of the eligible individual or, as applicable, the individual's legal or designated representative.
(C) Dangerous conditions in the setting jeopardize the health or safety of the provider authorized and paid for by the Department, and necessary safeguards are not available to minimize the dangers.
(D) The individual does not have the ability to express their informed decision, does not have a designated representative to make decisions on their behalf, and the Department or case management entity are unable to take necessary safeguards to protect the individual's safety, health, and welfare.
(c) An ISP must not be authorized that includes types or amounts of developmental disabilities services for which the individual is not eligible.
(d) A case manager must present an individual, or as applicable the individual's legal or designated representative, with information on service alternatives and provide assistance to assess other choices when a provider or setting selected by the individual, or as applicable the individual's legal or designated representative, is not authorized.
(e) A services coordinator employed by a CDDP, or a sub-contractor of a CDDP contracted to deliver case management, may authorize an eligible individual to receive the following developmental disabilities services:
(A) Community First Choice (K Plan) services.
(B) Services described in the Children's Extraordinary Needs, Adults', and Children's, 1915(c) Home and Community-Based Services waivers.
(C) State Plan Personal Care as described in OAR chapter 411, division 455.
(D) Private duty nursing as described in OAR chapter 410, division 132.
(E) Family support services as described in OAR chapter 411, division 305.
(f) A personal agent may authorize an eligible individual to receive the following developmental disabilities services:
(A) Community First Choice (K Plan) services, except services delivered as part of a residential program.
(B) Services described in the Adults' 1915(c) Home and Community-Based Services Waiver.
(C) State Plan Personal Care as described in OAR chapter 411, division 455.
(D) Private duty nursing as described in OAR chapter 410, division 132.
(g) A CIIS services coordinator may authorize an eligible individual to receive the following developmental disabilities services:
(A) Community First Choice (K Plan) services.
(B) Services described in the following 1915(c) waivers:
(i) Medically Involved Children's Waiver.
(ii) Medically Fragile (Hospital) Model Waiver.
(iii) Behavioral (ICF/IDD) Model Waiver.
(iv) Children's Extraordinary Needs Waiver.
(C) State Plan Personal Care as described in OAR chapter 411, division 455.
(D) Private duty nursing as described in OAR chapter 410, division 132 and OAR 411-300-0150.
(h) The Department authorizes entry for:
(A) Children into residential programs.
(B) Children's Intensive In-Home Services (CIIS).
(C) The Children's Extraordinary Needs Program.
(D) The Stabilization and Crisis Unit.
(10) ANNUAL PLANS. An individual enrolled in case management services, but not accessing Community First Choice

(K Plan) or waiver services, must have an Annual Plan.

(a) A case manager must develop an Annual Plan within 90 calendar days from the date of the individual's enrollment into case management services, and annually thereafter if the individual is not enrolled in any Community First Choice (K Plan) or waiver services.

(b) An Annual Plan must be developed as follows:

(A) For an adult individual, a written Annual Plan must be documented as an Annual Plan or as a comprehensive progress note in the individual's service record and include all of the following:

(i) A review of the individual's current living situation.

(ii) A review of the individual's employment status and a summary of any related support needs.

(iii) A review of any personal health, safety, or behavioral concerns.

(iv) A summary of the individual's support needs.

(v) Actions to be taken by the case manager and others.

(B) For a child receiving family support services, a services coordinator must coordinate with the child and the child's parent or legal representative in the development of an Annual Plan. The Annual Plan for a child receiving family support services must be in accordance with OAR 411-305-0225.

(c) An Annual Plan must be kept current. A case manager must ensure that a current Annual Plan is maintained for each individual receiving services.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.105, 427.115, 427.154, 427.191, 430.212, 430.662, 430.731

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.005-427.154, 427.191, 430.212, 430.215, 430.610, 430.620, 430.662, 430.664, 430.731-430.768

AMEND: 411-415-0080

REPEAL: Temporary 411-415-0080 from APD 25-2024

RULE TITLE: Accessing Developmental Disabilities Services

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-415-0080 about accessing developmental disabilities services is being amended to improve readability, ensure consistency, reflect rule writing standards, and require case management entities to:

- Annually inform parents and guardians about the Children's Extraordinary Needs Program and how to apply for the program.
- Assist with adding any child to the waitlist for the Children's Extraordinary Needs Program regardless of service group, if requested.
- Attempt to contact a child's parent or guardian within two weeks from the date the case management entity receives notification that a child has been offered enrollment in the Children's Extraordinary Needs Program.
- Inform the Office of Developmental Disabilities Services of a parent's or guardian's decision to participate in the Children's Extraordinary Needs Program.
- Provide a list of any provider agencies willing to consider employing parent providers to those who choose to participate in the Children's Extraordinary Needs Program.
- Inform a child, prior to the child's enrollment in the Children's Extraordinary Needs Program, about advocating for themselves with respect to choosing and managing their own direct support professionals.

RULE TEXT:

(1) A case management entity is required to:

(a) Provide assistance in finding and arranging resources, services, and supports. When an individual or the individual's legal or designated representative chooses to receive supports delivered by a personal support worker, a case management entity must not limit their choice of qualified providers, including all those available on the Home Care Commission Registry.

(b) Provide information and technical assistance to an individual, and as applicable the individual's legal or designated representative, in order to make informed decisions. This may include, but is not limited to, information about support needs, settings, programs, and types of providers.

(c) Provide a brief description of the services available from the case management entity, including typical timelines for activities, required assessments, monitoring and other activities required for participation in a Medicaid program, and the planning process.

(d) Inform an individual, or as applicable the individual's legal or designated representative, of any potential conflicts of interest between the case management entity and providers available to the individual.

(e) Inform a provider of the responsibility:

(A) To carry out their duty as a mandatory reporter of suspected abuse; and

(B) To immediately notify anyone specified by an individual of any incident that occurs when the provider is delivering services when the incident may have a serious effect on the individual's health, safety, physical, or emotional well-being, or level of services required.

(2) In accordance with the rules for home and community-based services in OAR chapter 411, division 004, an individual, or as applicable the individual's legal or designated representative, must be advised regarding non-residential service options including employment services and non-residential community living supports. For services considered, a non-disability specific setting option must be presented and documented in an individual's person-centered service plan.

(3) WRITTEN INFORMATION REQUIRED. A case manager must give a provider the relevant content from an individual's ISP that is necessary for the provider to deliver the services the provider is authorized to deliver, prior to the start of services. The content must include the relevant risks included in an individual's Risk Management Plan. The risks are relevant when they may reasonably be expected to threaten the health and safety of the individual, the

provider, or the community at large without appropriate precautions during the delivery of the service authorized for the provider to deliver. If an individual, or as applicable the individual's legal representative, refuses to disclose the information, a case management entity must disclose the refusal to the provider, who may choose to refuse to deliver the services.

(a) The necessary information is conveyed on a Department approved Service Agreement containing the required content. For an agency provider or independent provider who is not a personal support worker, an ISP may be used in lieu of a Service Agreement with an individual's consent.

(b) A personal support worker must be provided a copy of a finalized Service Agreement no later than seven calendar days from when a common law employer and the personal support worker signed the Service Agreement.

(c) For an agency operator of a residential program or employment program, a case manager must provide all of the following to the agency:

(A) A document indicating safety skills, including an individual's ability to evacuate from a building when warned by a signal device and adjust water temperature for bathing and washing.

(B) A brief written history of any behavioral challenges, including supervision and support needs.

(C) A record of known communicable diseases and allergies.

(D) Copies of protocols, the risk tracking record or risk identification tool, and any support documentation (if applicable).

(E) Copies of documents relating to a health care representative or health care advocate.

(F) A copy of the most recent Positive Behavior Support Plan and assessment, Nursing Service Plan, and mental health treatment plan (if applicable).

(d) In addition to subsection (c) of this section, a residential program must be given all of the following:

(A) A copy of the eligibility determination document.

(B) A medical history and information on health care supports that includes (when available):

(i) The results of a most recent physical exam.

(ii) The results of any dental evaluation.

(iii) A record of immunizations.

(iv) A record of major illnesses and hospitalizations.

(v) A written record of any current or recommended medications, treatments, diets, and aids to physical functioning.

(C) A copy of the most recent functional needs assessment. If the needs of an individual have changed over time, the previous functional needs assessments must also be provided.

(D) Copies of documents relating to the guardianship or conservatorship, power of attorney, court orders, probation and parole information, or any other legal restrictions on the rights of an individual (if applicable).

(E) Written documentation that an individual is participating in out-of-residence activities, including public school enrollment for individuals less than 21 years of age.

(F) A copy of any completed and signed forms documenting consent to an individually-based limitation described in OAR 411-004-0040. The form must be signed by the individual or, if applicable, the individual's legal representative.

(e) In addition to subsection (c) of this section, an agency provider of employment services must be given:

(A) The Career Development Plan.

(B) Protocols that are necessary to assure the individual's health and safety.

(f) When an individual is known to be accessing Vocational Rehabilitation services, the Vocational Rehabilitation counselor must be given the individual's Career Development Plan.

(g) If an individual is being entered into a residential program from their family home and the information required in subsections (c) and (d) of this section are not available, a case manager must ensure that the residential program provider assesses the individual upon entry for issues of immediate health or safety.

(A) The case manager must develop and document a plan to secure the information listed in subsections (c) and (d) of this section no later than 30 calendar days after entry.

(B) The plan must include a written justification as to why the information is not available and a copy of the plan must be

given to the provider at the time of entry.
(4) CHILDREN'S EXTRAORDINARY NEEDS (CEN) PROGRAM.
(a) At least annually and regardless of service group, a case management entity must inform a child's parent or guardian that their child may be eligible for the CEN Program and provide information about how to apply for the program.
(b) If requested and regardless of service group, a case management entity must assist with adding a child to the Department's waitlist for the CEN Program.
(c) When a child's parent or guardian has been offered enrollment to the CEN Program by the Department, a case management entity must:
(A) Attempt to contact the child's parent or guardian within two weeks from the date the Department informed the case management entity of the child's offer to enroll in the CEN Program.
(B) Inform the Department of the parent's or guardian's decision, or lack of response, no later than 60 calendar days from the date the parent or guardian was notified by the Department of the offer to enroll in the CEN Program. During the 60 calendar day period, the case management entity must make no less than three attempts to contact the parent or guardian through various formats such as phone call, text message, and email.
(C) Provide or direct a parent or guardian who chooses to participate in the CEN Program to a list of any provider agencies willing to consider employing a parent provider.
(d) Prior to a child's enrollment in the CEN Program, as described in OAR chapter 411, division 440, a CME must provide information to the child about advocating for themselves with respect to choosing and managing direct support professionals.
(5) ENTRY MEETING.
(a) No later than the date of an individual's entry into a residential program, a case manager must convene a meeting of the ISP team to review referral material in order to determine appropriateness of entry.
(b) An entry meeting may be held for entry into services other than a residential program when a member of the ISP team requests one.
(c) A potential provider may request an entry meeting and may refuse entry to an individual who refuses to permit an entry meeting.
(d) Findings of an entry meeting must be recorded in an individual's service record and distributed to ISP team members. The findings of an entry meeting must include, at a minimum:
(A) The name of the individual proposed for services.
(B) The date of the entry meeting.
(C) The date determined to be the date of entry.
(D) Documentation of the participants included in the entry meeting.
(E) Documentation of information required by section (3) of this rule when entering a residential program.
(F) Documentation of the decision to serve the individual requesting services.
(6) TRANSFER MEETING.
(a) A meeting of the ISP team must precede any transfer of an individual that was not initiated by the individual, or as applicable the individual's legal representative, unless the individual declines to have a meeting.
(b) Findings of a transfer meeting must be recorded in an individual's service record and include, at a minimum:
(A) The name of the individual considered for transfer.
(B) The date of the transfer meeting.
(C) Documentation of the participants included in the transfer meeting.
(D) Documentation of the circumstances leading to the proposed transfer.
(E) Documentation of the alternatives considered instead of transfer.
(F) Documentation of the reasons any preferences of the individual, or as applicable the legal or designated representative or family members of the individual, may not be honored.
(G) Documentation of the decision regarding the transfer, including verification of the voluntary decision to transfer or a copy of the Notice of Involuntary Reduction, Transfer, or Exit.

(H) The written plan for services for the individual after the transfer.
(7) EXIT MEETING.
(a) A case manager must offer an individual, and as applicable the individual's legal or designated representative, an opportunity to convene the ISP team prior to the individual's exit from a residential program, agency provided employment services, or community living services other than relief care.
(b) Findings of an exit meeting must be recorded in an individual's service record and include, at a minimum:
(A) The name of the individual considered for exit.
(B) The date of the exit meeting.
(C) Documentation of the participants included in the exit meeting.
(D) Documentation of the circumstances leading to the proposed exit.
(E) Documentation of the discussion of the strategies to prevent the individual's exit from services, unless the individual or their legal representative is requesting the exit.
(F) Documentation of the decision regarding the individual's exit, including verification of the voluntary decision to exit or a copy of the Notice of Involuntary, Reduction, Transfer, or Exit.
(G) The written plan for services for the individual after the exit.
(c) Requirements for an exit meeting may be waived if an individual or the individual's legal representative, if applicable, declines to have an exit meeting or the individual is immediately removed from the applicable program under the following conditions:
(A) The individual or their legal representative requests an immediate exit from the program.
(B) The individual is removed by legal authority acting pursuant to civil or criminal proceedings other than detention for an individual less than 18 years of age.
(8) INDEPENDENT PROVIDERS. When services are provided by an independent provider:
(a) A case manager must provide an individual, and as applicable the individual's legal or designated representative, a brief description of the responsibilities for use of public funds.
(b) Using the Department approved Service Agreement, a case management entity must inform an independent provider engaged to provide supports to an individual of all of the following:
(A) The type and amount of services authorized in the individual's ISP for the independent provider to deliver.
(B) Behavioral, medical, known risks, and other information about the individual that is required for the provider to safely and adequately deliver services to the individual.
(C) When present, safety protocols and a copy of the most recent Positive Behavior Support Plan and Nursing Service Plan must be attached to the Service Agreement.
(c) COMMON LAW EMPLOYER. A case management entity must assure that a person is identified to act as a common law employer for a personal support worker in accordance with OAR 411-375-0055.
(A) A case management entity may require intervention as defined in OAR 411-375-0055.
(B) A case management entity may deny a request for an employer representative if the requested employer representative has any of the following:
(i) A history of substantiated or founded abuse.
(ii) Participated in billing excessive or fraudulent charges.
(iii) Failed to meet the employer responsibilities described in OAR 411-375-0055, including previous termination as a result of failing to meet the employer responsibilities.
(C) A case management entity must mail a notice informing an individual, and as applicable the individual's legal or designated representative, when:
(i) The case management entity removes an employer from performing the employer responsibilities described in OAR 411-375-0055.
(ii) The case management entity removes an employer representative from performing the employer responsibilities because the employer representative does not meet the qualifications of an employer representative.
(D) If an individual, or as applicable the legal or designated representative or employer representative of the individual,

is dissatisfied with the decision of a case management entity to remove an employer or employer representative, the individual, or as applicable their legal or designated representative or employer representative, may request reinstatement as described in OAR 411-375-0055 or file a complaint with the case management entity or Department as described in OAR 411-318-0015.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.105, 427.115, 427.154, 427.191, 430.212, 430.662, 430.731

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.005-427.154, 427.191, 430.212, 430.215, 430.610, 430.620, 430.662, 430.664, 430.731-430.768

AMEND: 411-415-0090

REPEAL: Temporary 411-415-0090 from APD 25-2024

RULE TITLE: Case Management Contact and Monitoring of Services

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-415-0090 about case management contact and monitoring of services is being amended to:

- Specify monthly case management contact must be provided to a child enrolled in the Children's Extraordinary Needs Program, including a minimum of two in-person case management contacts per year.
- Improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

(1) CASE MANAGEMENT CONTACT.

(a) Every individual who has an ISP must have a case management contact no less than once every three months.

(A) The purpose of a case management contact must be to assure one of the following:

(i) Known health and safety risks are adequately addressed.

(ii) An individual's support needs have not significantly changed.

(iii) An individual and the individual's legal or designated representative are satisfied with the current services and supports.

(B) Over the course of an ISP year, a case manager must assure subsections (i) through (iii) of section (A) are met.

(b) Monthly case management contact must be provided:

(A) To an individual with three or more significant health and safety risks as identified in a Risk Management Plan;

(B) If determined to be necessary by a case manager; or

(C) To a child enrolled in the Children's Extraordinary Needs Program.

(c) For a child, reciprocal contact with the child's parent or legal representative may substitute for contact with the child, except as specified in subsection (d) and if the parent or legal representative is not being paid to deliver attendant care to the child.

(d) At least one case management contact per year must be in person with an individual, including when an individual is a child. If an individual or the individual's legal representative agrees, other case management contact may be made by telephone or by other interactive methods. A child enrolled in the Children's Extraordinary Needs Program must have a minimum of two in-person case management contacts per year.

(e) The outcome of all case management contact must be recorded in an individual's progress notes.

(2) MONITORING OF SERVICES: A case manager must conduct monitoring activities using the framework described in this section.

(a) A case manager is required to provide assistance to an individual or the individual's legal or designated representative with monitoring and improving the quality of supports.

(b) For an individual with an ISP that authorizes waiver or Community First Choice (K Plan) services, monitoring must include an assessment of all of the following:

(A) Are services being provided as described in the ISP and do the services result in the achievement of the identified action plans?

(B) Are the individual's personal, civil, and legal rights protected in accordance with OAR chapter 411, division 318?

(C) Are the individual's personal desires, and as applicable the legal or designated representative or family of the individual, addressed?

(D) Do the services authorized in the ISP continue to meet the individual's assessed needs and what is important to, and for, the individual?

(E) Do identified desired outcomes and associated goals and action plans remain relevant and are the goals supported and being met?

(F) Are technological and adaptive equipment and environmental modifications being maintained and used as intended?

(G) Have changing needs or availability of other resources altered the need for continued use of Department funds to purchase supports?
(H) Are the services delivered in a setting that is in compliance with OAR 411-004-0020(1)?
(I) Are all the necessary protocols or mitigation strategies present that are needed to keep the individual healthy and safe?
(c) For an individual receiving employment services, a case manager must:
(A) Assess the progress of the individual toward competitive integrated employment; and
(B) When an individual is receiving facility-based employment path services, visit each setting at least twice per plan year, while the individual is present, to verify and document the progress being made to support the individual to achieve employment goals documented in the Career Development Plan. Visits must be at least three months apart.
(d) When a case manager receives an incident report documenting the use of an emergency physical restraint, the case manager must review the use for potential abuse.
(e) When a case manager becomes aware of the wrongful use of a physical or chemical restraint, as described in ORS 430.735, the case manager must document the following efforts:
(A) Direction to the provider, and as applicable the common law employer, that the use of such restraint must immediately cease.
(B) Notification to the individual and the individual's legal representative of the individual's right to be free from unauthorized restraint.
(C) Report of potential abuse by the wrongful use of a physical or chemical restraint.
(f) When a case manager receives three incident reports in a six-month period documenting the use of an emergency physical restraint, the case manager must assess the effectiveness of existing services authorized in an individual's ISP and take appropriate action.
(g) When an individual or the individual's legal representative has consented to an individually-based limitation, service monitoring must include an evaluation of the ongoing need for the limitation.
(h) Unless specified in these rules, the minimum frequency of service monitoring must be determined by a case manager, based on an individual's needs, and not less than once per plan year.
(i) For an individual receiving only case management services and not enrolled in any other funded developmental disabilities services, a case manager must make contact with the individual at least once annually.
(A) Whenever possible, annual contact must be made in person. If annual contact is not made in person, a progress note in the service record must document how contact was achieved.
(B) If the individual has any identified high-risk medical issue including, but not limited to, risk of death due to aspiration, seizures, constipation, dehydration, diabetes, or significant behavioral issues, the case manager must maintain contact in accordance with planned actions as described in the Annual Plan.
(j) For an individual who is enrolled in a residential program, the monitoring of services may be combined with the site visits described in section (3) of this rule. In addition:
(A) During the ISP year, a services coordinator must review, at least once, services specific to health, safety, and behavior, using questions established by the Department.
(B) A semi-annual review of the process by which an individual accesses and utilizes their own funds must occur, using questions established by the Department. A services coordinator must determine whether financial records, bank statements, and personal spending funds are correctly reconciled and accounted for.
(i) The financial review standards for 24-hour residential programs are described in OAR 411-325-0380.
(ii) The financial review standards for adult foster homes are described in OAR 411-360-0170.
(iii) Any misuse of funds must be reported to the CDDP and the Department. The Department determines whether a referral to the Medicaid Fraud Control Unit is warranted.
(C) A services coordinator must monitor reports of serious incidents.
(k) If State Plan Personal Care services are authorized in an Annual Plan, the services must be monitored as described in OAR 411-455-0030.

(3) SITE VISITS.
(a) A CDDP must ensure that a quarterly site visit is conducted at each child or adult foster home, each host home, and each 24-hour residential program setting licensed by the Department to serve individuals with intellectual or developmental disabilities. A person conducting a site visit must meet the qualifications of a case manager described in OAR 411-415-0040. An assessor may not fulfill the site visit requirement.
(b) A CDDP must establish an annual schedule for site visits to each site that is owned, operated, or controlled by:
(A) An employment program certified and endorsed according to OAR chapter 411, division 345.
(B) A provider agency delivering community living supports certified and endorsed according to OAR chapter 411, division 450.
(c) A CDDP must conduct at least one visit annually to the home of an individual receiving services in a supported living setting.
(d) When services are anticipated to be delivered in an individual’s home, a case management entity must conduct at least one visit annually to the individual's home.
(e) Site visits may be increased for any of the following reasons including, but not limited to:
(A) Increased certified and licensed capacity.
(B) New individuals receiving services.
(C) Newly licensed or certified and endorsed provider.
(D) An abuse investigation.
(E) A serious incident.
(F) A change in the management or staff of the licensed site or certified and endorsed program operator.
(G) An ISP team request.
(H) Significant change in the functioning of an individual who receives services at the site.
(f) A case management entity must develop a procedure for the conduct of a site visit.
(g) A case management entity must document a site visit and provide information concerning the site visit to the Department upon request.
(h) If there are no Department-funded individuals at a site, a visit by a case management entity is not required.
(i) When a provider is a Department-contracted and licensed, certified, and endorsed 24-hour residential program for children and a children's residential services coordinator for the Department is assigned to monitor services, the children's residential services coordinator and the CDDP shall coordinate the site visit. If the site visit is made by Department staff, Department staff shall provide the results of the site visit to the local services coordinator.
(j) The Department may conduct site visits on a more frequent basis than described in this section based on program needs.
(4) MONITORING FOLLOW-UP. A case manager and a case management entity are responsible for ensuring the appropriate follow-up to monitoring of services, except in the instance of children in 24-hour residential programs directly contracted with the Department when the Department conducts the follow-up.
(a) If a case manager determines developmental disabilities services are not being delivered as agreed in an individual's ISP, or that an individual's service needs have changed since the last review, the case manager must initiate at least one of the following actions:
(A) Update the individual's ISP.
(B) To remediate service delivery shortcomings, provide or refer technical assistance to an agency provider or common law employer for a personal support worker.
(b) If there are concerns regarding the ability of a provider to deliver services, a case management entity must determine the need for technical assistance or other follow-up activities, such as:
(A) Coordination or provision of technical assistance.
(B) Referral to a CDDP manager or brokerage director for consultation or corrective action.
(C) Requesting assistance from the Department for licensing or other administrative support.
(D) Meeting with a provider's executive director or board of directors.

(c) A case management entity must ensure that there is monitoring and follow-up on serious incidents.

(5) DEPARTMENT NOTIFICATION. A case management entity must notify the Department when:

(a) A provider demonstrates substantial failure to comply with any applicable licensing, certification, or endorsement rules for Department-funded programs.

(b) A personal support worker may have met any of the conditions identified in OAR 411-375-0070 that would cause the Department to inactivate or terminate the personal support worker's provider enrollment.

(c) The case management entity finds a serious and current threat endangering the health, safety, or welfare of an individual in a program.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.105, 427.115, 427.154, 427.191, 430.212, 430.662, 430.731

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.005-427.154, 427.191, 430.212, 430.215, 430.610, 430.620, 430.662, 430.664, 430.731-430.768

AMEND: 411-435-0030

REPEAL: Temporary 411-435-0030 from APD 25-2024

RULE TITLE: General Eligibility for Ancillary Services

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-435-0030 about general eligibility for ancillary services is being amended to include the Children's Extraordinary Needs Program and improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

(1) An individual may not be denied ancillary services or otherwise discriminated against on the basis of race, color, religion, sex, gender identity, sexual orientation, national origin, marital status, age, disability, source of income, duration of Oregon residence, or other protected classes under federal and Oregon Civil Rights laws.

(2) To be eligible for ancillary services, an individual must meet the following requirements:

(a) Be an Oregon resident who meets the residency requirements in OAR 461-120-0010.

(b) Be enrolled with a case management entity.

(c) Be determined eligible for developmental disabilities services by the Community Developmental Disabilities Program of the county of origin according to OAR 411-320-0080, except for those enrolled in the following:

(A) A child enrolled in the Medically Involved Children's Program must meet the eligibility requirements in OAR 411-300-0120(7).

(B) A child enrolled in the Medically Fragile Children's Program must meet the eligibility requirements in OAR 411-300-0120(5).

(C) A child enrolled in the Children's Extraordinary Needs Program must meet the eligibility requirements in OAR 411-440-0030.

(d) Be receiving one of the following:

(A) Family support services as described in OAR chapter 411, division 305. A child who is eligible for family support funds may access ancillary services according to the conditions in OAR 411-305-0230.

(B) A Medicaid Title XIX benefit package through Oregon Supplemental Income Program-Medical (OSIPM) or Health System Division (HSD) medical programs. Individuals receiving Medicaid Title XIX through HSD medical programs for services in a nonstandard living arrangement, as defined in OAR 461-001-0000, are subject to the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(i) The transfer of assets as set forth in OAR 461-140-0210 through 461-140-0300.

(ii) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(C) A benefit package through Healthier Oregon.

(e) Be determined to meet a Level of Care, as defined in OAR 411-317-0000, except for individuals receiving family support services as described in OAR chapter 411, division 305.

(f) Demonstrate a need for an ancillary service as documented in an ISP or Annual Plan.

(g) For individuals with excess income, contribute to the cost of service in accordance with OAR 461-160-0610 and OAR 461-160-0620, except for individuals receiving family support services as described in OAR chapter 411, division 305.

(h) For services funded through the Community First Choice (K Plan) or a 1915(c) waiver, participate in a functional needs assessment and provide information necessary to complete the functional needs assessment and reassessment within the time frame required by the Department.

(A) Failure to participate in the functional needs assessment or to provide information necessary to complete the functional needs assessment or reassessment within the applicable time frame results in the denial or termination of service eligibility. In the event service eligibility is denied or terminated, a written Notification of Planned Action must be provided as described in OAR 411-318-0020.

(B) The Department may allow additional time if circumstances beyond the control of the individual, or as applicable the

individual's legal representative, prevent timely participation in the functional needs assessment or timely submission of information necessary to complete the functional needs assessment or reassessment.
(3) An individual enrolled to a residential program who meets the general eligibility criteria in this rule may be eligible for services equivalent to the ancillary services described in these rules through the residential program's rate.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 430.215, 430.610, 430.662

AMEND: 411-435-0060

REPEAL: Temporary 411-435-0060 from APD 25-2024

RULE TITLE: Developmental Disabilities - Waiver Ancillary Services

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-435-0060 about developmental disabilities - waiver ancillary services is being amended to:

- Include the Children's Extraordinary Needs Program by generally referring to ODDS' 1915(c) waivers.
- Improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

(1) The following ancillary services are available through a 1915(c) waiver, as defined in OAR 411-317-0000:
(a) Environmental safety modifications as described in section (3) of this rule.
(b) Family training as described in section (4) of this rule.
(c) Specialized medical supplies as described in section (5) of this rule.
(d) Vehicle modifications as described in section (6) of this rule.
(2) Environmental safety modifications, family training, and specialized medical supplies may also be available through family support funds within the service limits described in OAR 411-305-0230.
(3) ENVIRONMENTAL SAFETY MODIFICATIONS.
(a) To be eligible for environmental safety modifications, an individual must not be enrolled in a residential program, unless the enrollment is in a supported living program described in OAR chapter 411, division 328 and the dwelling is not a provider owned, controlled, or operated setting.
(b) Fencing may not exceed 200 linear feet without the Department's approval.
(c) Environmental safety modifications exclude the following:
(A) Large gates, such as automobile gates.
(B) Adaptations or improvements to the home not directly connected to an individual's identified needs.
(C) Adaptations adding to the total square footage of the home.
(D) Adaptations prohibited by local codes and ordinances or neighborhood Covenants, Conditions, and Restrictions (CCR).
(d) Environmental safety modifications must relate to an individual's health, welfare, or safety or increase an individual's independence in their home.
(e) Department approval is required for environmental safety modification expenditures over $5,000 per plan year and funded through a 1915(c) waiver.
(A) A case manager must request Department approval for additional expenditures prior to expenditure.
(B) Department approval is based on an individual's service and support needs and goals and the Department's determination of appropriateness and cost-effectiveness.
(C) Separate environmental safety modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.
(f) Environmental safety modifications must be completed by a state licensed contractor with a minimum of $1,000,000 liability insurance. Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. A contractor must have the certificate prior to payment.
(g) Payment to the contractor is withheld until the work meets specifications.
(h) A scope of work must be completed for each identified environmental safety modification project. All contractors submitting bids must be given the same scope of work.
(i) For all environmental safety modifications, a minimum of three written bids are required from providers meeting the qualifications in OAR 411-435-0080. When it is not reasonable to obtain three written bids, exceptions to this requirement may be granted by the Department.
(j) A case manager must assure the processes outlined in the Expenditure Guidelines are followed for contractor bids

and the awarding of work.
(k) All dwellings must be in good repair and have sound structure to safely support the environmental safety modification.
(l) The identified home may not be in foreclosure or the subject of legal proceedings regarding ownership.
(m) Environmental safety modifications must only be completed to an individual's primary residence.
(n) Environmental safety modifications are subject to Department requirements regarding material and construction practices based on industry standards for safety, liability, and durability, as referenced in building codes, materials, manuals, and industry and risk management publications.
(o) RENTAL PROPERTY.
(A) Environmental safety modifications to a rental property may not substitute or duplicate services otherwise the responsibility of the landlord as outlined in the landlord tenant laws, the Americans with Disabilities Act, or the Fair Housing Act.
(B) Environmental safety modifications made to a rental structure must have written authorization from the owner of the rental property prior to the start of the work.
(C) The Department does not fund work to restore a rental property to the condition it was in prior to the installation of an environmental modification.
(4) FAMILY TRAINING.
(a) To be eligible to access family training, an individual must not be enrolled in a residential program.
(b) Family training services include the following:
(A) Instruction about supports, medications, and use of equipment specified in an individual's ISP or Annual Plan.
(B) Information, education, and training about an individual's disability, medical, or behavioral conditions.
(C) Registration fees for organized conferences and workshops specifically related to an individual's intellectual or developmental disability or an individual's identified, specialized, medical, or behavioral support needs.
(c) Family training services exclude the following:
(A) Mental health counseling, medical treatment, or therapy.
(B) Training for a paid provider, including a paid family member.
(C) Legal fees.
(D) Training for a family member to carry out educational activities in lieu of school.
(E) Vocational training for family members.
(F) Paying for training to carry out activities or interventions the Department deems to constitute abuse of an individual.
(G) Travel, food, and lodging expenses.
(5) SPECIALIZED MEDICAL SUPPLIES. Specialized medical supplies include, but are not limited to:
(a) Various medical items, such as incontinence, nutrition, and infection control supplies.
(b) Supplies necessary to the proper functioning of life support equipment.
(c) Supplies that address physical conditions.
(d) Supplies necessary for the continued operation of augmentative communication devices or systems.
(6) VEHICLE MODIFICATIONS.
(a) To be eligible to access vehicle modifications, an individual must not be enrolled in a residential program.
(b) Vehicle modifications may only be made to the vehicle primarily used by an individual to meet the individual's unique needs.
(c) Vehicle modifications may include a lift, interior alterations to seats, head and leg rests, belts, special safety harnesses, other unique modifications to keep an individual safe in the vehicle, and the upkeep and maintenance of a modification made to the vehicle.
(d) Vehicle modifications exclude the following:
(A) Adaptations or improvements to a vehicle that are of general utility.
(B) The purchase or lease of a vehicle.

(C) Routine vehicle maintenance and repair.
(e) Department approval is required for vehicle modification expenditures over $5,000 per plan year and funded through a 1915(c) waiver.
(A) A case manager must request Department approval for additional expenditures prior to expenditure.
(B) Approval is based on an individual's service and support needs and goals and the Department's determination of appropriateness and cost-effectiveness.
(C) Separate vehicle modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.
(f) Vehicle modifications must meet applicable standards of manufacture, design, and installation.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 430.215, 430.610, 430.662

ADOPT: 411-440-0010

REPEAL: Temporary 411-440-0010 from APD 19-2024

RULE TITLE: Statement of Purpose for the Children's Extraordinary Needs (CEN) Program

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-440-0010 about the statement of purpose for the Children's Extraordinary Needs (CEN) Program is being adopted to establish standards, responsibilities, and procedures for the CEN Program.

RULE TEXT:

(1) The rules in OAR chapter 411, division 440 establish standards, responsibilities, and procedures for the Children's Extraordinary Needs (CEN) Program to ensure eligible children enrolled in the program receive high-quality care from a parent provider that complies with applicable state and federal law.

(2) The CEN Program is for children from birth through age 17, assessed to have very high medical or very high behavioral needs requiring extraordinary care.

(3) Through the CEN Program, provider agencies employ parent providers to deliver no more than 20 hours of attendant care to their child each week.

(4) The intent of the CEN Program is to not displace non-parent providers. Provider agencies shall continue to recruit, train, and retain non-parent providers.

(5) The CEN Program is subject to the approval of the Children's Extraordinary Needs 1915(c) Waiver by the Centers for Medicare and Medicaid Services.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.191, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 427.191, 430.215, 430.610, 430.662

ADOPT: 411-440-0020

REPEAL: Temporary 411-440-0020 from APD 19-2024

RULE TITLE: Definitions and Acronyms for the Children's Extraordinary Needs (CEN) Program

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-440-0020 about definitions and acronyms for the Children's Extraordinary Needs (CEN) Program is being adopted to establish standards, responsibilities, and procedures for the CEN Program.

RULE TEXT:

In addition to the following definitions and acronyms, OAR 411-317-0000 includes general definitions for words and terms frequently used in OAR chapter 411, division 440. If a word or term is defined differently in OAR 411-317-0000, the definition in this rule applies.

(1) "Abbreviated School Day Program" means an education program in which a school district restricts access for a student with a disability to hours of instruction or educational services to less than the number of hours of instruction or educational services provided to the majority of other students, in the same grade, within the student's resident school district, for more than 10 school days per school year.

(2) "Attendant Care" is defined in OAR 411-317-0000 and described in OAR 411-450-0060.

(3) "Children's Extraordinary Needs (CEN) Program" means the program where a parent of a child is paid by a provider agency to deliver attendant care to their child.

(4) "Child" is an individual under the age of 18.

(5) "Client Child" means a child receiving paid supports from a parent provider.

(6) "Completed Application" means the application created by the Department is filled out accurately and contains all of the information needed to add a child to the waitlist for the Children's Extraordinary Needs Program.

(7) "Direct Support Professional" means a person hired, employed, trained, paid, and supervised by a provider agency to provide attendant care services to a client of the agency.

(8) "Family" is defined in OAR 411-450-0020.

(9) "Good Cause" means an excusable mistake, surprise, excusable neglect (which may include neglect due to a significant cognitive or health issue) due to:

(a) Circumstances beyond the control of a person;

(b) Reasonable reliance on the statement of Department staff, a case management entity, or a provider agency relating to procedural requirements; or

(c) Fraud, misrepresentation, or other misconduct of the Department or party adverse to the person.

(10) "Health Systems Division Medical Programs" is defined in OAR 410-200-0015.

(11) "Medically Fragile Model Waiver" is defined in OAR 411-300-0110.

(12) "Medically Involved Children's Waiver" is defined in OAR 411-300-0110.

(13) "Ownership Interest" is when a person:

(a) Has an ownership interest totaling 5 percent or more in a provider agency;

(b) Has an indirect ownership interest equal to 5 percent or more in a provider agency.

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a provider agency;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a disclosing entity if that interest equals at least 5 percent of the value of the property or assets of a provider agency;

(e) Is an officer or director of a provider agency;

(f) Is a partner in a provider agency that is organized as a partnership; or

(g) Is a member of the board of directors of a provider agency.

(14) "Parent" means the biological parent, adoptive parent, stepparent, or legal guardian of a child.

(15) "Parent Provider" means a parent employed by a provider agency as a direct support professional to deliver hourly attendant care to their own child.

(16) "These Rules" mean the rules in OAR chapter 411, division 440.

(17) "Very High Behavioral":
(a) Means an Oregon Needs Assessment has determined a General Support Need Score for a child and the child:
(A) Exhibits at least two behaviors identified in OAR 411-450-0060, Table 4, in the section about the Behavior Support Need Score; and
(B) Has a current Positive Behavior Support Plan, as described in OAR 411-304-0150(5), to address the behaviors identified in subsection (A) of this section.
(b) May also be known as "service group 5b" or "5b".
(18) "Very High Medical":
(a) Means an Oregon Needs Assessment has determined a General Support Need Score for a child and the child requires a support person to perform a medical task identified in OAR 411-450-0060, Table 4, in the section about the Support Person Performs Score at least daily.
(b) May also be known as "service group 5m" or "5m".
(19) "Waitlist" means a list maintained by the Department for the purpose of determining the order of enrollment into the Children's Extraordinary Needs Program when a space in the program becomes available.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.191, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 427.191, 430.215, 430.610, 430.662

ADOPT: 411-440-0030

REPEAL: Temporary 411-440-0030 from APD 19-2024

RULE TITLE: General Eligibility and Exits for the Children's Extraordinary Needs (CEN) Program

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-440-0030 about general eligibility and exits for the Children's Extraordinary Needs (CEN) Program is being adopted to establish standards, responsibilities, and procedures for the CEN Program.

RULE TEXT:

(1) A child may not be denied services or otherwise discriminated against on the basis of race, color, religion, sex, gender identity, sexual orientation, national origin, marital status, age, disability, source of income, duration of Oregon residence, or other protected classes under federal and Oregon Civil Rights laws.

(2) Initial and ongoing determinations of eligibility for the CEN Program are the sole responsibility of the Department.

(3) To be eligible for the CEN Program, a child must meet all of the following requirements:

(a) Be an Oregon resident who meets the residency requirements in OAR 461-120-0010.

(b) Be determined eligible for developmental disabilities services by the Community Developmental Disabilities Program of the county of origin according to OAR 411-320-0080; or be enrolled in, or on, the waitlist for the Medically Involved Children's Waiver or the Medically Fragile Model Waiver Program as described in OAR chapter 411, division 300.

(c) Be receiving a Medicaid Title XIX benefit package through Oregon Supplemental Income Program-Medical (OSIPM) or Health Systems Division medical programs.

(d) Be determined to meet a Level of Care as defined in OAR 411-317-0000.

(e) Be assigned to the highest service group due to their very high medical or very high behavioral needs according to a current and valid Oregon Needs Assessment.

(f) Be receiving services in the child's family home.

(4) A child must be exited from the CEN Program if:

(a) The child turns 18 years of age.

(b) The child no longer meets the eligibility requirements described in section (3) of this rule.

(c) Monthly case management contact by a services coordinator, as described in OAR 411-415-0090(1), is not accepted.

(d) The child's parent is not employed by a provider agency to provide attendant care for their child 90 calendar days after the child is enrolled in the CEN Program. The Department may extend this time period when the Department determines there is good cause.

(e) The parent provider does not deliver attendant care to their child for 90 consecutive days. The Department may extend this time period when the Department determines there is good cause.

(f) The child enters a residential program, except as described in section (6) of this rule.

(5) When a child is being exited from the CEN Program because the child no longer meets the eligibility requirement described in section (3)(e) of this rule, the child may remain in the CEN Program until the end of the month following the month in which a functional needs assessment determines the child is no longer assigned to the highest service group with very high medical or very high behavioral needs.

(6) A child whose parent voluntarily withdraws their child from the CEN Program to enroll the child in a residential program, may return to the CEN Program until the end of the month following the month the child entered the residential program.

(7) NOTIFICATION OF PLANNED ACTION. Prior to a child exiting from the CEN Program, the Department shall provide a written advance Notification of Planned Action (form 0947) as described in OAR 411-318-0020.

(8) HEARINGS.

(a) A hearing is addressed according to ORS chapter 183 and OAR 411-318-0025.

(b) A parent may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.191, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 427.191, 430.215, 430.610, 430.662

ADOPT: 411-440-0040

REPEAL: Temporary 411-440-0040 from APD 19-2024

RULE TITLE: Qualifications for Parent Providers in the Children's Extraordinary Needs (CEN) Program

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-440-0040 about qualifications for parent providers for the Children's Extraordinary Needs (CEN) Program is being adopted to establish standards, responsibilities, and procedures for the CEN Program.

RULE TEXT:

(1) A parent provider must be employed by a provider agency certified in accordance with OAR chapter 411, division 323 with an endorsement to operate as either a community living supports agency or a standard model agency as defined in OAR chapter 411, division 450. A person cannot be employed by a provider agency as a parent provider if the parent or a member of the parent's family has an administrative role, leadership role, or ownership interest, in the provider agency.

(2) A parent provider must meet all of the qualifications established for provider agency staff in OAR 411-323-0050(8) and any additional qualifications established by the provider agency.

(3) A parent provider must be the parent of the client child.

(4) A parent must be hired by a provider agency to be a parent provider within 90 calendar days of a child’s enrollment to the CEN Program.

(5) A parent provider must deliver attendant care at least once every 90 calendar days.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.191, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 427.191, 430.215, 430.610, 430.662

ADOPT: 411-440-0050

REPEAL: Temporary 411-440-0050 from APD 19-2024

RULE TITLE: Service Requirements, Limitations, and Exclusions for the Children's Extraordinary Needs (CEN) Program

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-440-0050 about service requirements, limitations, and exclusions for the Children's Extraordinary Needs (CEN) Program is being adopted to establish standards, responsibilities, and procedures for the CEN Program.

RULE TEXT:

(1) The Department shall only reimburse a provider agency for the delivery of attendant care described in OAR 411-450-0060(2) by a parent provider.

(2) A provider agency may not be paid using Department funds for the delivery of attendant care by a parent provider in any of the following circumstances:

(a) During the hours available to a client child at the public school where the client child is or could be enrolled, except:

(A) When the client child is temporarily absent from school due to surgery or illness; or

(B) When a school district places the client child on an abbreviated school day program; or

(C) When the client child has been expelled or suspended.

(b) Due to a parent's choice to have the client child attend public or private school for fewer hours than the regular instructional hours of the child's assigned public school.

(c) For activities that do not meet the definition of attendant care, including homeschooling, tutoring, or that are a supplement to the public, private, or homeschool education of a client child.

(d) While simultaneously caring for or supervising a child under 10 years old or a vulnerable person of any age who requires physical care and monitoring. For the purpose of this rule, "vulnerable person" means a person who requires physical care and monitoring who is:

(A) 65 years of age or older;

(B) Financially incapable as defined in ORS 125.005;

(C) Incapacitated as defined in ORS 125.005; or

(D) A person with a disability who is susceptible to force, threat, duress, coercion, persuasion, or physical or emotional injury because of the person's physical or mental impairment.

(e) During the course of activities not for the primary benefit of the client child, such as:

(A) Grocery shopping for the parent provider's household.

(B) Housekeeping not required for the disability-related support needs of the client child.

(C) Remote work or the operation of a home business.

(D) Transporting individuals other than the client child to activities or appointments.

(f) When any condition described in OAR 411-450-0050(8) is present.

(g) The child is 18 years old or older.

(3) A parent provider may not act as a client child's legal or designated representative in connection with the provision of Department-funded supports.

(4) A child may not be enrolled in the CEN Program while enrolled in a residential program.

(5) A child's legal or designated representative who authorizes the child's ISP is required to participate in monthly case management contact as described in OAR 411-415-0090(1).

(6) A child's legal or designated representative must permit at least two case management contacts per ISP year, separated by no fewer than 90 calendar days, to occur in person with the child.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.191, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 427.191, 430.215, 430.610, 430.662

ADOPT: 411-440-0060

REPEAL: Temporary 411-440-0060 from APD 19-2024

RULE TITLE: Training Requirements for the Children's Extraordinary Needs (CEN) Program

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-440-0060 about training requirements for the Children's Extraordinary Needs (CEN) Program is being adopted to establish standards, responsibilities, and procedures for the CEN Program.

RULE TEXT:

(1) A parent provider must complete Department-approved training prior to delivering services to their child under these rules. The training must include:

(a) An overview of federal and state administrative rules regulating home and community-based services; and

(b) The impact of providing Department-funded services on parent-child relationships with respect to discipline, supervision, physical intervention, and self-determination of a client child.

(2) A client child must receive age-appropriate, accessible training, information, or materials related to self-advocacy with respect to choosing their own direct support professionals prior to being enrolled in the CEN program.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.191, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 427.191, 430.215, 430.610, 430.662

ADOPT: 411-440-0070

REPEAL: Temporary 411-440-0070 from APD 19-2024

RULE TITLE: Initial Enrollments for the Children's Extraordinary Needs (CEN) Program

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-440-0070 about initial enrollments for the Children's Extraordinary Needs (CEN) Program is being adopted to establish standards, responsibilities, and procedures for the CEN Program.

RULE TEXT:

(1) The Department has identified all children who have very high behavioral or very high medical needs, or who are on the waitlist for the Medically Fragile Model Waiver or the Medically Involved Children's Waiver as of May 2, 2024. Only these children shall be considered for initial enrollment to the CEN Program.

(2) The Department assigned a unique five digit number to each child identified in section (1) of this rule and used a random generator to shuffle the five digit numbers to determine the top 155 children offered enrollment into the CEN Program and the order of the waitlist, described in OAR 411-440-0080, by their randomly assigned number.

(3) The parent of a child selected for initial enrollment must affirm to the child's case management entity their decision to participate in the CEN Program no later than July 19, 2024.

(4) If a parent declines to participate in the CEN Program by July 19, 2024:

(a) The child does not retain the number assigned to them according to section (2) of this rule.

(b) The Department shall offer the parent a choice for their child to be moved to the end of the waitlist or removed from the waitlist. If the parent of the child does not indicate a choice, the child is removed from the Department's waitlist as described in OAR 411-440-0080.

(5) If a parent does not respond to the offer to participate in the CEN Program by July 19, 2024:

(a) The child does not retain the number assigned to them according to section (2) of this rule.

(b) The child will be moved to the end of the waitlist.

(6) The Department shall confirm a child selected for initial enrollment to the CEN Program meets the eligibility requirements in OAR 411-440-0030(3). If the child is determined ineligible, the Department shall provide a written advance Notification of Planned Action (form 0947) as described in OAR 411-318-0020.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.191, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 427.191, 430.215, 430.610, 430.662

ADOPT: 411-440-0080

REPEAL: Temporary 411-440-0080 from APD 19-2024

RULE TITLE: Ongoing Enrollments for the Children's Extraordinary Needs (CEN) Program

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-440-0080 about ongoing enrollments for the Children's Extraordinary Needs (CEN) Program is being adopted to establish standards, responsibilities, and procedures for the CEN Program.

RULE TEXT:

(1) The Department shall maintain a waitlist for the CEN Program if the maximum number of children allowed on the approved CEN Waiver are enrolled in the CEN Program. Children on the waitlist may access other Medicaid or General Fund services for which the child is eligible.

(2) After the initial waitlist is established as described in OAR 411-440-0070, additional applicants for the CEN Program shall be moved to the end of the waitlist based on the completed application date for the CEN Program. The Department will not accept an application for a child to be added to the waitlist before November 1, 2024.

(3) A child may be removed from the waitlist if:

(a) The child is enrolled in the CEN Program.

(b) The child moves out of Oregon.

(c) The parent of the child requests their removal in writing to the Department or the child's case management entity.

(d) The child is determined ineligible for services provided by the Department.

(e) The child is deceased.

(f) The child turns 18 years old.

(4) A child who is removed from the waitlist must reapply to be added to the waitlist.

(5) When a child exits the CEN Program, the Department must offer enrollment to the CEN Program to the child next on the waitlist. If the parent of the child highest on the waitlist declines or does not respond to an offer to enroll in the CEN Program, or the child does not meet the eligibility criteria for the program under these rules, access to the CEN Program must be offered to the next child on the waitlist. This process must continue until 155 children are enrolled in the CEN Program.

(6) The parent of a child selected for enrollment must affirm to the child's case management entity their decision to participate in the CEN Program no later than 60 calendar days from the date the parent was notified of the offer to enroll in the CEN Program.

(7) If a parent declines to participate in the CEN Program:

(a) The child does not retain their number on the waitlist.

(b) The Department shall offer the parent a choice to be moved to the end of the waitlist or removed from the waitlist. If the parent of the child does not indicate a choice, the child is removed from the waitlist.

(8) If a parent or does not respond to the offer to participate in the CEN Program within 60 calendar days from the date the parent was notified of the offer to enroll in the CEN Program:

(a) The child does not retain their number on the waitlist.

(b) The child is moved to the end of the waitlist.

(9) The Department shall confirm a child selected for enrollment to the CEN Program meets the eligibility requirements in OAR 411-440-0030(3). If a child is determined ineligible at the time of the offer to enroll in the CEN Program, the Department shall provide a written advance Notification of Planned Action (form 0947) as described in OAR 411-318-0020.

(10) If a child is not eligible for the CEN Program when offered enrollment:

(a) The child does not retain their number on the waitlist.

(b) The Department shall offer the parent a choice to be moved to the end of the waitlist or removed from the waitlist. If the parent of the child does not respond, the child is removed from the waitlist.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.191, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 427.191, 430.215, 430.610, 430.662

ADOPT: 411-440-0090

REPEAL: Temporary 411-440-0090 from APD 19-2024

RULE TITLE: Complaints about the Children's Extraordinary Needs (CEN) Program

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-440-0090 about complaints for the Children's Extraordinary Needs (CEN) Program is being adopted to establish standards, responsibilities, and procedures for the CEN Program.

RULE TEXT:

(1) Complaints related to the administration of the CEN Program must be made directly to the Department and may be made orally, in writing, or by using the Department's Complaint Form (0946).

(2) A complaint shall be addressed by the Department according to OAR 411-318-0015.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.104, 427.191, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.101, 427.104, 427.191, 430.215, 430.610, 430.662

AMEND: 411-450-0020

REPEAL: Temporary 411-450-0020 from APD 25-2024

RULE TITLE: Definitions and Acronyms for Community Living Supports

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-450-0020 about definitions and acronyms for community living supports is being amended to include definitions for the Children's Extraordinary Needs Program and improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

In addition to the following definitions and acronyms, OAR 411-317-0000 includes general definitions for words and terms frequently used in OAR chapter 411, division 450. If a word or term is defined differently in OAR 411-317-0000, the definition in this rule applies.

(1) "ADL" means "Activities of Daily Living" as defined in OAR 411-317-0000.

(2) "Alternative Resources" is defined in OAR 411-317-0000.

(3) "ANA-C" means the Adult In-Home Support Needs Assessment, Version C. The Department incorporates the ANA-C into these rules by this reference.

(4) "Assessor" is defined in OAR 411-317-0000.

(5) "Attendant Care" is defined in OAR 411-317-0000.

(6) "Authorized ISP" means an Individual Support Plan that meets the criteria in OAR 411-415-0070(8)(e).

(7) "CDDP" means "Community Developmental Disabilities Program" as defined in OAR 411-317-0000.

(8) "Children's Extraordinary Needs (CEN) Program" is defined in OAR 411-440-0020 and described in OAR chapter 411, division 440.

(9) "Class" means group attendant care that is regularly occurring, organized, and structured around specific supports in activities of daily living or instrumental activities of daily living intended to maintain or enhance an individual's skill level in the activities of daily living or instrumental activities of daily living.

(10) "CNA-C" means the Child In-Home Support Needs Assessment, Version C. The Department incorporates the CNA-C into these rules by this reference.

(11) "Community Living Supports Agency" means a provider agency certified under OAR chapter 411, division 323 and endorsed to these rules, excluding OAR 411-450-0090, to deliver community living supports.

(12) "Day Support Activities" means attendant care supports, delivered by a provider agency, that happen during scheduled, intentional, structured activities in a non-residential setting. Day support activities focus on maintaining or enhancing the skills an individual needs to engage with the community.

(13) "Direct Support Professional" means a person hired, employed, trained, paid, and supervised by a provider agency to provide attendant care services to a client of the agency.

(14) "DSA" means "Day Support Activities" as defined in this rule.

(15) "Exception" means an approval granted by the Department, or the Department's designee, to alter a limit or condition on a service based on an individual's demonstrated need.

(16) "Facility-Based" means a service operated at a fixed site owned, operated, or controlled by a service provider where an individual has few or no opportunities to interact with people who do not have a disability except for paid staff.

(17) "Family":

(a) Means a unit of two or more people that includes at least one individual, found to be eligible for developmental disabilities services, where the primary caregiver is:

(A) A family member as defined in OAR 411-317-0000; or

(B) In a domestic relationship where partners share the following:

(i) A permanent residence.

(ii) Joint responsibility for the household in general, such as child-rearing, maintenance of the residence, and basic living

expenses.
(iii) Joint responsibility for supporting the individual when the individual is related to one of the partners by blood, marriage, or legal adoption.
(b) This definition of family is used when determining an individual's service eligibility for community living supports as a resident in the family home.
(18) "Group Activity" means an organized or impromptu day support activity that involves more than one individual supported by the same provider agency.
(19) "Healthier Oregon" is defined in OAR 410-120-0000 and described in OAR chapter 410, division 134.
(20) "Health System Division (HSD) Medical Programs" is defined in OAR 410-200-0015.
(21) "Hour Allocation" means the number of monthly hours authorized in an Individual Support Plan for any combination of attendant care, day support activities, skills training services, private duty nursing as described in OAR 411-300-0150, direct nursing services as described in OAR chapter 411, division 380, and state plan personal care as described in OAR chapter 411, division 455.
(22) "IADL" means "Instrumental Activities of Daily Living" as defined in OAR 411-317-0000.
(23) "IDEA" means the Individuals with Disabilities Education Act, 20 U.S.C §1400.
(24) "Implementation Strategy" means a written description of the steps a provider agency will take to assist an individual to achieve the individual's desired outcomes, increase independence, and build or maintain skills, as identified in the individual's Individual Support Plan or Service Agreement, and assigned to the provider agency to implement.
(25) "Informal Arrangement" means a paid or unpaid arrangement for shelter or utility costs that does not include the elements of a rental agreement.
(26) "ISP" means "Individual Support Plan" as defined in OAR 411-317-0000.
(27) "Natural Support" is defined in OAR 411-317-0000.
(28) "ODDS" means the Oregon Department of Human Services, Office of Developmental Disabilities Services.
(29) "ONA" means "Oregon Needs Assessment" as defined in OAR 411-317-0000 and described in OAR 411-425-0055.
(30) "Oregon Supplemental Income Program-Medical" is defined in OAR 411-317-0000.
(31) "Ownership Interest" means a person that:
(a) Has an ownership interest totaling 5 percent or more in a provider agency;
(b) Has an indirect ownership interest equal to 5 percent or more in a provider agency;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a provider agency;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a provider agency if that interest equals at least 5 percent of the value of the property or assets of the provider agency;
(e) Is an officer or director of a provider agency;
(f) Is a partner in a provider agency that is organized as a partnership; or
(g) Is a member of the board of directors of a provider agency.
(32) "Parent Provider" is defined in OAR 411-440-0020 for the Children's Extraordinary Needs Program.
(33) "Primary Caregiver" means the person identified in an Individual Support Plan as providing the majority of services and support for an individual in the individual's home.
(34) "Progress Report" means a written document that summarizes an individual's progress, the evidence of the progress, and a provider agency's activities undertaken towards achieving the individual's desired outcomes of increased independence and skill building or maintenance, as identified in the individual's Individual Support Plan or Service Agreement.
(35) "Provider-Owned Dwelling" means a dwelling that is owned by a provider or the provider's spouse, when the provider is proposing to be paid for delivering home and community-based services to an individual, and the provider or the provider's spouse is not related to the individual by blood, marriage, or adoption. A provider-owned dwelling includes, but is not limited to:
(a) A house, apartment, and condominium.

(b) A portion of a house, such as a basement or a garage, even when remodeled to be used as a separate dwelling.
(c) A trailer and mobile home.
(d) A duplex unless the structure displays a separate address from the other residential unit and was originally built as a duplex.
(36) "Provider-Rented Dwelling" means a dwelling that is rented or leased by a provider or the provider's spouse, when the provider is proposing to be paid for delivering home and community-based services to an individual, and the provider or the provider's spouse is not related to the individual by blood, marriage, or adoption.
(37) "PSW" means "Personal Support Worker" as defined in OAR 411-317-0000.
(38) "Rental Agreement" means a payment arrangement for shelter or utility costs with a property owner, property manager, or landlord that includes all of the following elements:
(a) The name and contact information for the property owner, property manager, or landlord.
(b) The period or term of the agreement and method for terminating the agreement.
(c) The number of tenants or occupants.
(d) The rental fee and any other charges, such as security deposits.
(e) The frequency of payments, such as monthly.
(f) What costs are covered by the amount of rent charged, such as shelter, utilities, or other expenses.
(g) The duties and responsibilities of the property owner, property manager, or landlord and the tenant, such as:
(A) The person responsible for maintenance;
(B) If the property is furnished or unfurnished; and
(C) Advance notice requirements prior to an increase in rent.
(39) "Scheduled Support" means an attendant care or skills training support that a representative of a provider agency and an individual agree to at least 48 hours ahead of the anticipated service delivery.
(40) "Service Level" means the maximum number of hours available to an individual in a month for any combination of attendant care, day support activities, skills training services, private duty nursing as described in OAR 411-300-0150, direct nursing services as described in OAR chapter 411, division 380, or state plan personal care as described in OAR chapter 411, division 455, based on an assessment required by the Department.
(41) "Skills Training" is defined in OAR 411-317-0000.
(42) "Staffing Ratio" means the number of paid providers to the number of individuals in their care at the same time.
(43) "Standard Model Agency" means a provider agency certified under OAR chapter 411, division 323 and endorsed to these rules, including OAR 411-450-0090, to deliver community living supports.
(44) "These Rules" mean the rules in OAR chapter 411, division 450.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.024, 427.104, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.024, 427.104, 427.181, 430.215, 430.610, 430.662

AMEND: 411-450-0030

REPEAL: Temporary 411-450-0030 from APD 25-2024

RULE TITLE: Eligibility for Community Living Supports

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-450-0030 about eligibility for community living supports is being amended to include the Children's Extraordinary Needs Program and improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

(1) An individual may not be denied community living supports or otherwise discriminated against on the basis of race, color, religion, sex, gender identity, sexual orientation, national origin, marital status, age, disability, source of income, duration of Oregon residence, or other protected classes under federal and Oregon Civil Rights laws.

(2) To be eligible for community living supports, an individual must meet the following requirements:

(a) Be an Oregon resident who meets the residency requirements in OAR 461-120-0010.

(b) Be determined eligible for developmental disabilities services by the Community Developmental Disabilities Program of the county of origin according to OAR 411-320-0080, except for those enrolled in the following:

(A) A child enrolled in the Medically Involved Children's Program must meet the eligibility requirements in OAR 411-300-0120(7).

(B) A child enrolled in the Medically Fragile Children's Program must meet the eligibility requirements in OAR 411-300-0120(5).

(C) A child enrolled in the Children's Extraordinary Needs Program must meet the eligibility requirements in OAR 411-440-0030.

(c) Choose to use a case management entity for assistance with the design and management of developmental disabilities services.

(d) Be receiving a Medicaid Title XIX benefit package through Oregon Supplemental Income Program-Medical (OSIPM) or Health Systems Division(HSD) medical programs or a benefit package through Healthier Oregon.

(A) An adult is eligible for community living supports if the adult had been receiving community living supports as a child up to their 18th birthday and has not become ineligible due to section (2)(d)(B) of this rule.

(B) Eligibility for community living supports based on section (2)(d)(A) of this rule ends if:

(i) The individual does not apply for a disability determination and Medicaid within 10 business days of their 18th birthday;

(ii) The Social Security Administration or the Department's Presumptive Medicaid Disability Determination Team finds the individual does not have a qualifying disability; or

(iii) The individual is determined by the state of Oregon to be ineligible for a Medicaid Title XIX benefit package through OSIPM or HSD medical programs or a benefit package through Healthier Oregon.

(C) Individuals receiving Medicaid Title XIX through HSD medical programs for services in a nonstandard living arrangement, as defined in OAR 461-001-0000, are subject to the requirements in the same manner as if they were requesting these services under OSIPM, including the rules regarding:

(i) The transfer of assets as set forth in OAR 461-140-0210 through 461-140-0300.

(ii) The equity value of a home which exceeds the limits as set forth in OAR 461-145-0220.

(e) Be determined to meet the Level of Care as defined in OAR 411-317-0000.

(f) Individuals with excess income must contribute to the cost of services in accordance with OAR 461-160-0610 and OAR 461-160-0620.

(g) Participate in an Oregon Needs Assessment and provide information necessary to complete the Oregon Needs Assessment prior to receiving community living supports, annually, and as required by the Department.

(A) Failure to participate in the Oregon Needs Assessment or to provide information necessary to complete the Oregon Needs Assessment within the required time frame results in the denial or termination of service eligibility. In the event

service eligibility is denied or terminated, a written Notification of Planned Action must be provided as described in OAR 411-318-0020.

(B) The Department may allow additional time if circumstances beyond the control of the individual prevents timely participation in the Oregon Needs Assessment or timely submission of information necessary to complete the Oregon Needs Assessment.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.024, 427.104, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.024, 427.104, 427.181, 430.215, 430.610, 430.662

AMEND: 411-450-0060

REPEAL: Temporary 411-450-0060 from APD 25-2024

RULE TITLE: Community Living Supports

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-450-0060 about community living supports is being amended to:

- Establish a child enrolled in the Children's Extraordinary Needs Program may not receive more than 20 hours of attendant care in a workweek from a parent provider.
- Improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

(1) Department funds may be used to purchase the following community living supports when included in an authorized Individual Support Plan (ISP):

(a) Community living supports available through the Community First Choice (K Plan):

(A) Attendant care as described in section (2) of this rule.

(B) Skills training as described in section (3) of this rule.

(C) Relief care as described in section (4) of this rule.

(b) Community living supports available through the Children's Extraordinary Needs Waiver:

(A) Attendant care as described in section (2) of this rule, excluding the day support activities described in subsection (2)(e).

(B) Skills training as described in section (3) of this rule.

(2) ATTENDANT CARE SERVICES. Attendant care services include direct support provided to an individual in the individual's home or community by a qualified provider. Activities of daily living (ADL) and instrumental activities of daily living (IADL) delivered through attendant care must be necessary to permit an individual to live independently in a community-based setting.

(a) ADL services include, but are not limited to, the following:

(A) Basic personal hygiene. Providing or assisting with needs such as bathing (tub, bed, bath, shower), hair care, grooming, shaving, nail care, foot care, dressing, skin care, or oral hygiene.

(B) Toileting, bowel, and bladder care.

(i) Assisting to and from the bathroom or on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting.

(ii) Changing incontinence supplies.

(iii) Following a toileting schedule.

(iv) Managing menses.

(v) Cleansing an individual or adjusting clothing related to toileting.

(vi) Emptying a catheter, drainage bag, or assistive device.

(vii) Ostomy care.

(viii) Bowel care.

(C) Mobility, transfers, and repositioning.

(i) Assisting with ambulation or transfers with or without assistive devices.

(ii) Turning an individual or adjusting padding for physical comfort or pressure relief.

(iii) Encouraging or assisting with range-of-motion exercises.

(D) Eating.

(i) Assisting with adequate fluid intake or adequate nutrition.

(ii) Assisting with food intake (feeding).

(iii) Monitoring to prevent choking or aspiration.

(iv) Assisting with adaptive utensils, cutting food.

(v) Placing food, dishes, and utensils within reach for eating.

(E) Cognitive assistance or emotional support provided to an individual due to an intellectual or developmental disability.
(i) Helping the individual cope with change.
(ii) Assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive functions.
(b) IADL services include, but are not limited to, the following:
(A) Light housekeeping tasks necessary to maintain an individual in a healthy and safe environment.
(i) Cleaning surfaces and floors.
(ii) Making the individual's bed.
(iii) Cleaning dishes.
(iv) Taking out the garbage.
(v) Dusting.
(vi) Laundry.
(B) Grocery and other shopping necessary for the completion of other ADL and IADL tasks.
(C) Meal preparation and special diets.
(D) Support with participation in the community:
(i) Support with community participation. Assisting an individual in acquiring, retaining, and improving skills to use available community resources, facilities, or businesses, and improving self-awareness and self-control.
(ii) Support with communication. Assisting an individual in acquiring, retaining, and improving expressive and receptive skills in verbal and non-verbal language, social responsiveness, social amenities, and interpersonal skills, and the functional application of acquired reading and writing skills.
(c) Assistance with ADL, IADL, and health-related tasks may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may be provided through human assistance or the use of electronic devices or other assistive devices. Assistance may also require verbal reminding to complete any of the IADL tasks described in subsection (b) of this section.
(A) "Cueing" means giving verbal, audio, or visual clues during an ADL, IADL, or health-related task to help an individual complete the activity without hands-on assistance.
(B) "Hands-on" means a provider physically performs all or parts of an ADL, IADL, or health-related task because an individual is unable to do so.
(C) "Monitoring" means a provider observes an individual to determine if assistance is needed during the completion of an ADL, IADL, or health-related task.
(D) "Reassurance" means to offer an individual encouragement and support to complete an ADL, IADL, or health-related task.
(E) "Redirection" means to divert an individual to another more appropriate activity.
(F) "Set-up" means the preparation, cleaning, and maintenance of personal effects, supplies, assistive devices, or equipment so an individual may perform an ADL, IADL, or health-related task.
(G) "Stand-by" means a provider is at the side of an individual ready to step in and take over the ADL, IADL, or health-related task if the individual is unable to complete it independently.
(d) For a child, the child's primary caregiver is expected to be present or available during the provision of attendant care. ADL and IADL services provided through attendant care must support the child to live as independently as appropriate for the age of the child and support, but not supplant, the child's family in their primary caregiver role.
(e) DAY SUPPORT ACTIVITIES (DSA).
(A) DSA must include a focus on competencies around the IADLs identified in section (2)(b)(D) of this rule or be a class.
(B) DSA requires that an individual have a measurable goal documented in the individual's ISP that is related to developing or maintaining skills for participating in the community.
(C) DSA may only be delivered by a provider qualified to deliver community living supports according to OAR 411-450-0070(2) or (4).
(D) DSA must meet staffing requirements specified in an individual's ISP or Service Agreement. Direct service staff must

be present in sufficient number to meet health, safety, and service needs. DSA may not be delivered at the same time to more than eight individuals per agency staff member.
(E) Department approval is required to authorize DSA for individuals under age 18. DSA is only possible when services are not available through the Individuals with Disabilities Education Act.
(F) Facility-based DSA must, at minimum, provide on-going opportunities and encouragement to individuals for going out into the broader community.
(G) An individual may access DSA at a 1:1 (or greater) staffing ratio if any of the following apply:
(i) The individual does not want to participate in a group activity, the DSA is authorized in the individual's ISP, and the individual has a desired outcome to support the DSA.
(ii) The support needs of the individual require a 1:1 (or greater) staffing ratio in a group activity.
(iii) The DSA occur without other individuals receiving paid services at the same time from the same provider agency and the individual has a desired outcome to support the DSA.
(H) A provider agency may not design or allow a group activity where 1:1 is provided but not necessary to support an individual.
(3) SKILLS TRAINING. Skills training is specifically tied to accomplishing ADL, IADL, and other health-related tasks as identified by a functional needs assessment and an ISP and permitting an individual to live independently in a community-based setting.
(a) Skills training may be applied to the use and care of assistive devices and technologies.
(b) Skills training is authorized when:
(A) The anticipated outcome of the skills training, as documented in the ISP, is measurable.
(B) Timelines for measuring progress towards the anticipated outcome are established in the ISP.
(C) Progress towards the anticipated outcomes are measured and the measurements are evaluated by a case manager no less frequently than every six months, based on the start date of the initiation of the skills training.
(c) When anticipated outcomes are not achieved within the timeframe outlined in an individual's ISP, the individual's case manager must reassess or redefine the use of skills training with the individual for that particular goal.
(d) For a child, the child's primary caregiver is expected to be present or available during the provision of skills training. ADL and IADL services provided through skills training must support the child to live as independently as appropriate for the age of the child and support, but not supplant, the child's family in their primary caregiver role.
(e) Skills training may not replace or supplant the services of the educational system in fulfilling its obligation to educate an individual.
(4) RELIEF CARE.
(a) Relief care may not be characterized as daily or periodic services provided solely to allow a primary caregiver to attend school or work. Daily relief care may be provided in segments that are sequential.
(b) Relief care may be provided in any of the following:
(A) The home of an individual.
(B) A licensed or certified setting.
(C) The home of a qualified provider, chosen by an individual or their legal or designated representative, that is a safe setting for the individual.
(D) The community, during the provision of ADL, IADL, health-related tasks, and other supports identified in an individual's ISP.
(c) No other community living supports may be provided to an individual during a 24-hour unit of daily relief care.
(5) Community living supports may be delivered:
(a) Individually or in a group as indicated by the outcome of the person-centered planning process for an individual.
(b) In an individual's home, community, or a facility.
(A) Community living supports are facility-based if delivered outside of an individual's home at a fixed site operated, owned, or controlled by a provider.
(B) DSA may not be provided in a residential setting.

(6) SETTING LIMITATIONS.
(a) An individual may receive community living supports if the individual:
(A) Resides in a setting the individual owns, leases, or rents or is on the property deed, mortgage, or title.
(B) Resides in a setting, either through an informal arrangement or rental agreement, owned, leased, or rented by a family member.
(C) Has no permanent residence.
(b) An individual is not eligible for community living supports, other than DSA, if the individual resides in one of the following:
(A) A provider-owned dwelling or a provider-rented dwelling through an informal or formal arrangement.
(B) A provider owned, controlled, or operated setting, including a setting owned, controlled, or operated by an employee of a provider agency.
(c) An individual is not eligible for community living supports in a specific setting if:
(A) The Department determines the health and safety of the individual may not be reasonably maintained in the setting; or
(B) Dangerous conditions in the setting jeopardize the health or safety of the individual or provider, and the individual, or their legal or designated representative, is unable or unwilling to implement necessary safeguards to minimize the dangers.
(d) An individual enrolled in a residential program, an adult foster home for older adults or adults with physical disabilities licensed in accordance with OAR chapter 411, division 049, or a residential care or assisted living facility licensed in accordance with OAR chapter 411, division 054, is not eligible for the following:
(A) Community living supports provided by a personal support worker.
(B) Community living supports delivered in the home of the individual, whether the home is a licensed setting or not.
(C) Relief care.
(e) A child living in a Behavior Rehabilitation Services (BRS) Program as described in OAR chapter 410, division 170, or Psychiatric Residential Treatment Facility (PRTF) as defined in OAR 309-022-0105, is not eligible for community living supports.
(7) SERVICE LIMITS.
(a) All hour allocations, and staffing ratios greater than 1:1, for community living supports must be included in an authorized ISP.
(b) An individual who has had a completed Oregon Needs Assessment (ONA) is assigned to a service group for the purpose of determining a service level upon the individual's initial ISP or the first annual ISP renewal following the adoption of this rule, and annually thereafter. An individual may only be assigned to one service group. The service groups are:
(A) Very Low.
(B) Low.
(C) Moderate.
(D) High.
(E) Very High.
(F) Infant/Toddler.
(c) Service groups are determined by applying a numeric value based on the responses to specific items being assessed in the ONA and using the values to calculate scores (the value of each item by response may be found in table 4). This is done for seven areas of the ONA, generating the following seven scores:
(A) General Support Need (GSN) score.
(B) The Medical Support Need (MSN) score.
(C) The Support Person Performs score.
(D) The Behavior Support Need (BSN) score.
(E) The Behavior Intervention/Management Frequency score.

(F) The Positive Behavior Support Plan (PBSP) score.
(G) Emergency/Crisis Services score.
(d) The scores described in subsection (c) of this section are used to assign an individual a service group number according to table 1.
(e) The service group number identified in subsection (d) of this section assigns an individual to a service group based on the individual's age at the time the ONA was submitted, as shown in table 2.
(f) For an individual not enrolled to a residential program who has been assigned to a service group as described in subsection (b) of this section, the maximum monthly hour allocation that may be included in an authorized ISP for the assigned service group, by the age of the individual on the submission date of the ONA, is the greater of:
(A) Without an approved exception as described in OAR 411-450-0065, the service level shown in table 3;
(B) With an approved exception as described in OAR 411-450-0065, an amount up to the amount approved by the Department, no earlier than the date of the exception approval;
(C) The service level for the individual on the last day of an ISP that expires between December 2023 and December 2024, as determined by an Adult Needs Assessment, Version C (ANA-C) for an adult, or a Child Needs Assessment, Version C (CNA-C) for a child. This does not include hours that have been included for the purpose of increasing a staff ratio;
(D) An amount up to the number of private duty nursing hours determined as described in OAR 411-300-0150 for a child in the Medically Fragile Children's program; or
(E) For an individual initially accessing hourly attendant care services, the greater of an amount:
(i) Determined by an ANA-C for an adult, or a CNA-C for a child. This does not include hours that have been included for the purpose of increasing a staff ratio; or
(ii) A condition described in (A), (B), (C), or (D) of this subsection.
(g) A change to the score of an Oregon Needs Assessment must only result from an assessment conducted by an assessor who meets the qualification and training requirements identified in OAR 411-425-0035 and is employed by a case management entity or the Department.
(h) The ANA-C or CNA-C determines the following for an individual who has not been assigned to a service group under subsection (b) of this section:
(A) Without an approved exception as described in OAR 411-450-0065, the service level. The service level may not be exceeded without prior approval from the Department.
(B) Without an approved exception as described in OAR 411-450-0065 and when such a need is identified, the ANA-C or CNA-C determines the maximum number of hours two staff may be simultaneously available.
(i) An hour allocation included in an authorized ISP may not exceed the number of hours of community living supports that are determined by the person-centered planning process and informed by the ISP team to be necessary to meet identified support needs after consideration and assignment of voluntary natural supports and alternative resources.
(j) An increase to an hour allocation must be based on:
(A) An increase in support needs identified following a completed reassessment using an ONA conducted by an assessor;
(B) A short-term increase in support needs based on a change in the support needs expected to last no more than 90 calendar days, documented in the service record;
(C) The loss of a natural support or alternative resource identified in the ISP as the means of meeting an identified need;
(D) A choice not to continue the use of a natural support; or
(E) A choice to meet a previously unmet, identified need.
(k) When an ONA assigns an individual to a service group with a lower service level than the hour allocation authorized in an ISP at the time of the ONA, the individual may have access to the amount authorized in the ISP for no longer than the end of the month that follows the month in which the ONA was conducted. (The example used in this subsection of this rule is illustrative only and limited to the facts it contains.) Example: An ONA completed on April 10th assigned an adult to service group 2. The previous ONA had assigned the adult to service group 3. The hour allocation within the

service level for service group 3 is available to the adult through May 31st.
(l) When an ONA assigns an individual to a service group with a higher service level than the hour allocation authorized in an ISP at the time of the ONA, the individual may have access to an hour allocation within the new service level when it has been included in the authorized ISP.
(m) Unless an hour allocation below the service level is agreed to in advance and included in the individual's ISP, an individual must be given the opportunity for a hearing under ORS chapter 183 and OAR 411-318-0025 for any reduction in the authorized hour allocation.
(n) An hour allocation may not be reduced for anyone who has not been assigned to a service group as described in subsection (b) of this section.
(o) An hour allocation may not be reduced below the service level for the individual on the last day of an ISP that expires between December 2023 and December 2024, as determined by an ANA-C for an adult, or a CNA-C for a child. This does not include hours that have been included for the purpose of increasing a staff ratio.
(p) Any individual who is denied a requested hour allocation in an authorized ISP:
(A) Must be provided a Notice of Planned Action and given the opportunity for a hearing as described in ORS chapter 183 and OAR 411-318-0025; and
(B) May request an exception as described in OAR 411-450-0065.
(q) A child enrolled in the Children's Extraordinary Needs Program may not receive more than a total of 20 hours of attendant care from one or more parent providers in a workweek, not to exceed the child's total monthly hour allocation.
(8) STAFF RATIOS.
(a) Community living supports are delivered by a staffing ratio of one provider (agency employee, personal support worker, etc.) to one or more individuals, unless the need for two or more providers to be available simultaneously to provide community living supports to an individual has been determined to be necessary following a person centered planning process and, except as noted in section (7)(e)(B) of this rule, confirmed by review of an exception request as described in OAR 411-450-0065.
(b) The number of hours allocated for a staffing ratio of greater than 1:1 may not exceed the number of hours required to meet the need that requires the higher ratio.
(c) Unless agreed to in advance and included in the individual's authorized ISP, an individual must be given the opportunity for a hearing under ORS chapter 183 and OAR 411-318-0025 for any reduction in the authorized staffing ratio.
(d) Any individual who is denied a requested staffing ratio in an authorized ISP:
(A) Must be provided a Notice of Planned Action and given the opportunity for a hearing as described in ORS chapter 183 and OAR 411-318-0025; and
(B) May request an exception as described in OAR 411-450-0065.
(9) The Department may put limits on how Department funds and resources are used, as long as those limited funds and resources are adequate to meet the needs of an individual.
(10) For an individual enrolled in a residential program, an adult foster home for older adults or adults with physical disabilities licensed in accordance with OAR chapter 411, division 049, or a residential care or assisted living facility licensed in accordance with OAR chapter 411, division 054, receipt of any combination of job coaching, supported employment - small group employment support, employment path services, and DSA may not exceed 25 hours per week. Individuals residing in these settings, who do not receive employment services, may receive up to 25 hours of DSA per week.
(11) No more than 14 days of relief care in a plan year are allowed without approval from the Department. Each day of respite care described in and provided according to OAR 411-070-0043(5) contributes to the 14 day limit for relief care.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.024, 427.104, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.10, 427.007, 427.024, 427.104, 427.181, 430.215, 430.610, 430.662

411-450-0060 Community Living Supports

Table 1	
Score	Service Group Number
GSN score 14-22	1
GSN score 23-33	2
GSN score 34-53	3
GSN score 54-73	4
GSN score 74-84	5
Any GSN score with an MSN score of 5 or more And: A Support Person Performs score of 1 or more	5
Any GSN score with a BSN score of 2 or more And: PBSP score of 2 And: Behavior Intervention/Management Frequency score of 1 or more Or: Emergency/Crisis Services score of 1	5

Table 2

Adult (18 and older) and Adolescent (12-17 years old)	Service Group Number	Service Group
	1	Very Low
	2	Low
	3	Moderate
	4	High
	5	Very High

Child (4-11 years old)	Service Group Number	Service Group
	3	Very Low to Low
	4	Moderate
	5	High to Very High

Infant/Toddler (0-3)	Service Group Number	Service Group
	5	Infant/Toddler

Table 3

Adult (18 and older)	Service Group	Service Level
	Very Low	70
	Low	100
	Moderate	183
	High	369
	Very High	513

Adolescent (12-17 years old)	Service Group	Service Level (School Year)	Service Level (Summer)
	Very Low	56	74
	Low	87	104
	Moderate	104	122
	High	169	200
	Very High	239	282

Child (4-11 years old)	Service Group	Service Level (School Year)	Service Level (Summer)
	Very Low/ Low	83	91
	Moderate	96	109
	High/ Very High	152	174

Infant/Toddler (0-3 years old)	Service Group	Service Level
	Infant/Toddler	61

Table 4

General Support Need (GSN) Score

Below are the items that are used to create the GSN Score. The table includes the item number in the ONA, the item, notes on how to combine items when applicable (dressing and mobility items only), followed by the scores that are assigned to all possible responses. The area of general support need for each item in the ONA is indicated in the row above each item in that area. Responses range from 1 (independent) to 6 (dependent). Since some skills are not expected to be present for children under certain ages, skip patterns exist for items based on age. The highlighted column indicates that if a person is under the indicated age, their response is automatically recoded to a 6 (dependent). The next 3 columns are rules for coding “non-responses” or responses that are not on the scale from 1 (independent) to 6 (dependent). “Non-responses” are coded because to calculate a sum score that is consistent across all service recipients, all items must have a value. In the unlikely event of an item that has no response or is left blank, that item is not coded, and a service group is not assigned until the blank response is changed to a valid response.

Once all items are recoded to the specifications below, they are summed to become the GSN score.

Item #	Item	Combined items notes	Independent	Setup or Clean-up Assistance	Supervision or Touching Assistance	Partial/ Moderate Assistance	Substantial/ Maximal Assistance	Dependent	If Under (age), = 6	Not Applicable	Not Attempted	If Refused	If Not answered/blank
Area: Dressing													
3a	Upper Body Dressing - The ability to put on and remove shirt or pajama top. Includes buttoning, if applicable. *	Only use the least independent score out of the upper (3a) and lower	1	2	3	4	5	6	4	1	6	1	
3b	Lower Body Dressing - The ability to dress and undress below the waist, including fasteners. Does not include footwear.*		1	2	3	4	5	6	4	1	6	1	

3c	Putting on/taking off footwear - The ability to put on and take off socks and shoes or other footwear that are appropriate for safe mobility.*	(3b) dressing	1	2	3	4	5	6	4	1	6	1	
Area: Mobility													
5b	Walks 150 feet - Once standing, the ability to walk at least 150 feet in a corridor or similar space.*	Calculate by using score for wheels 150 feet and if that is null, then use walks 150 feet If both 5a and 5e are answered "no," , score mobility as Dependent (6).	1	2	3	4	5	6	3	1	6	1	
5f	Wheels 150 feet - Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space*		1	2	3	4	5	6	3	1	6	1	
Area: Eating and Tube Feeding													
6b	Eating - The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. *		1	2	3	4	5	6	4	1	6	1	
Area: Elimination													
7a	Toilet hygiene - The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. *		1	2	3	4	5	6	4	1	6	1	
Area: Showering and Bathing													
8a	Shower/bathe self - The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Include transferring in/out of tub/shower. *		1	2	3	4	5	6	5	1	6	1	
Area: Oral Hygiene													
9a	Oral Hygiene - The ability to use suitable items to clean teeth. [Dentures (if applicable) - The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.] *		1	2	3	4	5	6	5	1	6	1	
Area: General Hygiene													
10a	General Hygiene - The ability to perform other hygiene maintenance tasks, such as hair brushing, shaving, nail care, and applying deodorant. Note: Excludes toilet, and oral hygiene. *		1	2	3	4	5	6	5	1	6	1	

Area: Housework													
12a	Housework - The ability to safely and effectively maintain cleanliness of the living environment by washing cooking and eating utensils; changing bed linens; dusting; cleaning the stove, sinks, toilets, tubs/showers, and counters; sweeping, vacuuming, and washing floors; and taking out garbage. *		1	2	3	4	5	6	12	1	6	1	
Area: Meal preparation													
13a	Make a light meal - The ability to plan and prepare all aspects of a light meal such as a bowl of cereal or a sandwich and cold drink, or reheat a prepared meal. *		1	2	3	4	5	6	12	1	6	1	
Area: Laundry													
14a	Laundry - Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, adding laundry detergent, and folding laundry. *		1	2	3	4	5	6	12	1	6	1	
Area: Transportation													
15a	Use public transportation: The ability to plan and use public transportation. Includes boarding, riding, and disembarking from transportation. *		1	2	3	4	5	6	12	1		1	
Area: Money management													
16a	Money Management - The ability to manage finances for basic necessities (food, clothing, shelter), including counting money and making change, paying bills/writing checks, making budgeting and other financial decisions, and balancing checkbook. *		1	2	3	4	5	6	12	1	6	1	
Area: Light shopping													
17a	Light shopping - Once at store, can locate and select up to five groceries and personal care items, take to check out, and complete purchasing transaction. *		1	2	3	4	5	6	12	1	6	1	

Medical Support Need Score

Below are the items that are used to create the Medical support need score. The table includes the item number in the ONA and the item, followed by the scores that are assigned to all possible responses. Responses are recoded to 0 (does not receive), 1 (receives less than weekly), 2 (receives weekly or more but not daily), or 3 (receives daily or more).

Once all items are recoded to the specifications below, they are summed to become the MSN score.

Item #	Item	Has never needed	Does not currently need but has needed in the past	Needs but does not receive	Receives less than weekly	Receives weekly, fewer than 5 days per week	Receive weekly, 5 or more days per week	Receives daily	Receives 5 or more times per day
46b	Respiratory therapy	0	0	0	1	2	2	3	3
46b	Chest percussion (including percussion vest)	0	0	0	1	2	2	3	3
46b	Postural drainage	0	0	0	1	2	2	3	3
46b	Nebulizer	0	0	0	1	2	2	3	3
46b	Tracheal aerosol therapy	0	0	0	1	2	2	3	3
46b	Oral suctioning that does not extend beyond the oral cavity	0	0	0	1	2	2	3	3
46b	Airway suctioning	0	0	0	1	2	2	3	3
46b	Tracheal suctioning	0	0	0	1	2	2	3	3
46b	Nasopharyngeal suctioning	0	0	0	1	2	2	3	3
46b	Other suctioning	0	0	0	1	2	2	3	3
46b	Tracheostomy care	0	0	0	1	2	2	3	3
46b	Care for central line	0	0	0	1	2	2	3	3
46b	Intravenous (IV) injections/ infusions	0	0	0	1	2	2	3	3
46b	Subcutaneous injections	0	0	0	1	2	2	3	3
46b	Jejunostomy tube	0	0	0	1	2	2	3	3

46b	Nasogastric or abdominal feeding tube (e.g., g-tube, NG tube)	0	0	0	1	2	2	3	3
46b	Indwelling or suprapubic catheter monitoring	0	0	0	1	2	2	3	3
46b	Insertion of catheter (intermittent catheterization)	0	0	0	1	2	2	3	3
46b	CPAP/BiPAP	0	0	0	1	2	2	3	3
46b	Mechanical ventilator other than CPAP/BiPAP	0	0	0	1	2	2	3	3
46b	Oxygen therapy	0	0	0	1	2	2	3	3
46b	Colostomy, urostomy, and/or other ostomy	0	0	0	1	2	2	3	3
46b	Peritoneal dialysis	0	0	0	1	2	2	3	3
46b	Hemodialysis	0	0	0	1	2	2	3	3
46b	Active cerebral shunt monitoring	0	0	0	1	2	2	3	3
46b	Baclofen pump	0	0	0	1	2	2	3	3
46b	Wound care, excluding stage III or IV ulcers	0	0	0	1	2	2	3	3
46b	Treatment for stage III or IV ulcers (full loss of skin and tissue, may extend into muscle or bone)	0	0	0	1	2	2	3	3

Support Person Performs Score

For all of the same items in the previous section, the ONA also asks whether a support person performs the treatment/monitoring/therapy. These items are only scored when the same item is scored a 3 (receives daily or more) in the above MSN score section. For any items that have a 3 (receives daily or more), the support person item responses are coded as 0 (support person performs – no) or 1 (support person performs – yes).

Once all items are recoded to the specifications below, they are summed to become the Support Person Performs Score.

Item #	Item	If receives less than daily or support person performs - no	If receives daily or more and support person performs - yes
46b	Respiratory therapy	0	1
46b	Chest percussion (including percussion vest)	0	1
46b	Postural drainage	0	1
46b	Nebulizer	0	1
46b	Tracheal aerosol therapy	0	1
46b	Oral suctioning that does not extend beyond the oral cavity	0	1
46b	Airway suctioning	0	1
46b	Tracheal suctioning	0	1
46b	Nasopharyngeal suctioning	0	1
46b	Other suctioning	0	1
46b	Tracheostomy care	0	1
46b	Care for central line	0	1
46b	Intravenous (IV) injections/ infusions	0	1
46b	Subcutaneous injections	0	1
46b	Jejunostomy tube	0	1
46b	Nasogastric or abdominal feeding tube (e.g., g-tube, NG tube)	0	1
46b	Indwelling or suprapubic catheter monitoring	0	1
46b	Insertion of catheter (intermittent catheterization)	0	1
46b	CPAP/BiPAP	0	1

46b	Mechanical ventilator other than CPAP/BiPAP	0	1
46b	Oxygen therapy	0	1
46b	Colostomy, urostomy, and/or other ostomy	0	1
46b	Peritoneal dialysis	0	1
46b	Hemodialysis	0	1
46b	Active cerebral shunt monitoring	0	1
46b	Baclofen pump	0	1
46b	Wound care, excluding stage III or IV ulcers	0	1
46b	Treatment for stage III or IV ulcers (full loss of skin and tissue, may extend into muscle or bone)	0	1
46b	Behavioral health therapies, including mental health	0	1
46b	Psychiatric therapies/ services	0	1

Behavior Support Need Score

Below are the items that are used to create the Behavior support need score. The table includes the item number in the ONA and the item, followed by the scores that are assigned to all possible responses. The area of behavior support need for each item in the ONA is indicated in the row above each item in that area. Responses are recoded to 1 (Yes, present in past year) or 0 (all other responses).

Once all items are recoded to the specifications below, they are summed to become the BSN score.

Item #	Item	No history	Has history, no concern	Has history, concerns	No History, concerns	Yes, present in past year
Area: Injurious to self						
18a	Individual displays, or would without intervention, disruptive or dangerous behavioral symptoms not directed towards others, including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs). *	0	0	0	0	1
Area: Aggressive or combative						
19a	Individual displays physical behavior symptoms, or would without intervention, directed toward others (e.g., hits, kicks, pushes, or punches others, throws objects, spitting). *	0	0	0	0	1
Area: Sexual aggression/assault						
23a	Individual displays, or would without intervention, behaviors that are sexually aggressive (e.g., grabbing, thrusting) or assaultive (e.g., pushing up against wall and groping) towards others. *	0	0	0	0	1
Area: Property destruction						
24a	Individual engages in behavior, or would without intervention, that disassembles or damages public or private property or possessions. The individual is intentionally engaging in an act that leads to damage, though may not have the intent to cause damage. *	0	0	0	0	1

Behavior Intervention/Management Frequency Score

Below are the items that are used to create the Behavior intervention/management frequency score. The table below shows how both of the items are recoded. For the item on proactive strategies and physical prompts, a response of daily or more is coded to 1 and a response of less frequently than daily is recoded to 0. For the item on safeguarding interventions (also known as PPIs), a response of monthly or more is coded to 1 and a response of less frequently than monthly is coded to a 0.

Once all items are recoded to the specifications below, they are summed to become the Behavior intervention/management frequency score.

Item #	Item	None	Less than once per month	Once per month	More than once per month	1 – 3 times per week	4 or more times per week, but less than daily	Less than 5 times per day	More than 5 times per day
36b	How often does the individual require intervention and/or environment management due to any behavior issue (not specifically to each presenting behavior)? Proactive strategies and physical prompts	0	0	0	0	0	0	1	1
36c	How often does the individual require intervention and/or environment management due to any behavior issue (not specifically to each presenting behavior)? Safeguarding interventions (also known as PPIs)	0	0	1	1	1	1	1	1

Positive Behavior Support Plan Score

Below are the items about the Positive Behavior Support Plan (PBSP) that are used in the criteria for service group numbers. For both items, a response of "No" is recoded to 0 and a response of "Yes" is recoded to 1.

Once all items are recoded to the specifications below, they are summed to become the Positive Behavior Support Plan score.

Item #	Item	No	Yes
39a	Has a Positive Behavior Support Plan (PBSP) (also known as Behavior Support Plan or BSP) been created for the individual?	0	1
39b	Is the PBSP currently being implemented by support persons? (Support persons have been trained on the PBSP.)	0	1

Emergency/Crisis Services Score

Below is the item about emergency/crisis services that is used in the criteria for service group numbers. A response of “No” is recoded to 0 and a response of “Yes” is recoded to 1 for this item.

Once the item is recoded to the specifications below, it is the Emergency/crisis services score.

Item #	Item	No	Yes
39f	Has the individual required emergency services, crisis intervention services, or protective services to address a dangerous behavior 2 or more times in the past 12 months?	0	1

AMEND: 411-450-0080

REPEAL: Temporary 411-450-0080 from APD 25-2024

RULE TITLE: Minimum Standards for Provider Agencies Delivering Community Living Supports

NOTICE FILED DATE: 08/27/2024

RULE SUMMARY: OAR 411-450-0080 about minimum standards for provider agencies delivering community living supports is being amended to:

- Include parent provider training requirements.
- Allow parent providers for children enrolled in the Children's Extraordinary Needs Program when the parent provider and no other family members have an administrative or leadership role, or ownership interest, in a provider agency.
- Ensure parent providers comply with the Children's Extraordinary Needs Program rules in OAR chapter 411, division 440.
- Specify a provider agency may not allow a child to receive more than 20 hours total of attendant care from one or more parent providers in a workweek, not to exceed the child's total monthly hour allocation.
- Add reference to the rule including the conditions for when a parent provider is not eligible to be paid using ODDS funds for attendant care.
- Improve readability, ensure consistency, and reflect rule writing standards.

RULE TEXT:

(1) CERTIFICATION, ENDORSEMENT, AND ENROLLMENT. To be endorsed to operate a community living support program, a provider agency must have all of the following:

(a) A certificate and an endorsement, in accordance with OAR chapter 411, division 323, to deliver community living supports as a community living supports agency or a standard model agency.

(b) A Medicaid Agency Identification Number assigned by the Department in accordance with OAR chapter 411, division 370.

(2) INSPECTIONS AND INVESTIGATIONS. A provider agency must allow inspections and investigations in accordance with OAR 411-323-0040.

(3) MANAGEMENT AND PERSONNEL PRACTICES. A provider agency must comply with the management and personnel practices in OAR 411-323-0050.

(4) PRE-SERVICE TRAINING. A provider agency must maintain written documentation of six hours of pre-service training prior to staff supporting individuals that includes mandatory abuse reporting, ISPs, and Service Agreements.

(5) PARENT PROVIDER TRAINING. A provider agency must ensure a parent provider completes the training required in OAR 411-440-0060(1), prior to delivering services to their child.

(6) CONFIDENTIALITY OF RECORDS. A provider agency must ensure the confidentiality of individuals' records in accordance with OAR 411-323-0060.

(7) DOCUMENTATION REQUIREMENTS. Unless stated otherwise, all entries required by these rules must comply with the agency documentation requirements in OAR 411-323-0060.

(8) DAY SUPPORT ACTIVITIES. For DSA, a provider agency must develop and share the following information with an individual and the individual's case manager:

(a) A written plan or implementation strategies. The written strategies for service implementation must be given to an individual and the individual’s case manager within 60 calendar days of providing services for the ISP year.

(b) A risk mitigation strategy or protocol that addresses each identified relevant risk. The risk mitigation strategy or protocol must be given to an individual and the individual’s case manager before services begin for the ISP year.

(c) Other documents requested by the ISP team.

(9) PROGRESS NOTES AND RECORDS.

(a) A provider agency must maintain progress notes regarding the delivery of community living supports. A progress note must include, at minimum, all of the following information regarding the supports rendered:

(A) The date and time the support was delivered.
(B) The staff involved.
(C) Information regarding the nature of the support provided and how the support met an identified ADL or IADL support need or was a health-related task.
(b) Progress notes must be made available monthly and upon request by a case management entity.
(c) Failure to furnish written documentation upon the written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, Centers for Medicare and Medicaid Services, or their authorized representatives, immediately or within timeframes specified in the written request, may be deemed reason to recover payment.
(d) Records must be retained in accordance with OAR chapter 166, division 150, Secretary of State, Archives Division.
(A) Financial records, supporting documents, statistical records, and all other records (except individual records) must be retained for at least three years after the close of a contract period.
(B) Individual records must be kept for at least seven years.
(10) ABUSE AND INCIDENT HANDLING AND REPORTING. Complaints of abuse and the occurrence of serious incidents must be treated in accordance with OAR 411-323-0063.
(11) POLICIES AND PROCEDURES. A provider agency must develop and implement policies and procedures required for administration and operation in compliance with these rules including, but not limited to, all of the following:
(a) A provider agency must have, and implement, written policies and procedures protecting the individual rights in OAR 411-318-0010 and that:
(A) Provide for individual participation in selection, training, and evaluation of staff assigned to provide services to the individuals;
(B) Protect individuals during hours of service from financial exploitation that may include, but is not limited to, any of the following:
(i) Staff borrowing from, or loaning money to, an individual.
(ii) Witnessing wills in which staff or the provider agency may benefit directly or indirectly.
(iii) Adding the name of a staff member or provider agency to the bank account or other personal property of an individual without the approval of the individual or their legal representative (as applicable).
(b) Policies and procedures appropriate to the scope of service including, but not limited to, those required to meet the minimum standards in sections (15) through (28) of this rule and consistent with the ISPs or written Service Agreements for individuals currently receiving services.
(12) SERVICE DELIVERY. A provider agency must deliver services according to an individual's ISP or written Service Agreement.
(13) SERVICE RATES. Service rates, as authorized in the Department's electronic payment and reporting system for individuals authorized to receive community living supports and paid to a provider agency for delivering services as described in these rules, shall be reimbursed at the rate for a community living supports agency identified in the Expenditure Guidelines unless the provider agency is endorsed to operate a standard model agency in accordance with OAR 411-450-0090.
(14) BILLING. For a provider agency offering services to the general public, billings for Medicaid funds may not exceed the customary charges to private individuals for any like item or services charged by the provider agency.
(15) SERVICE RECORD. A provider agency must maintain a current service record for each individual receiving services. The individual's service record must include all of the following:
(a) The individual's name, current home address, and home phone number.
(b) The individual's current ISP or written Service Agreement.
(c) Contact information for the individual's legal or designated representative (as applicable) and any other people designated by the individual to be contacted in case of incident or emergency.
(d) Contact information for the case management entity assisting the individual to obtain services.
(e) Records of service provided, including type of services, dates, hours, and staff involved.
(f) For skills training, relief care services, and attendant care that does not meet the definition of DSA, an electronic

system must record all of the following for a service provided at the time of service:
(A) Type of service provided.
(B) Individual receiving service.
(C) Date of service provided.
(D) Location of service.
(E) Staff member providing the service.
(F) Start time of the service.
(G) End time of the service.
(16) TRAINING. A provider agency must ensure staff, contractors, and volunteers receive appropriate and necessary training.
(17) DRUG-FREE WORKPLACE. A provider agency regulated by these rules must be a drug-free workplace.
(18) SAFETY AND EMERGENCY PLANNING. A provider agency that owns or leases a site, delivers services to individuals at the site, and regularly has individuals present and receiving services at the site, must meet all of the following minimum requirements:
(a) A written emergency plan must be developed and implemented and must include instructions for staff and volunteers in the event of fire, explosion, accident, or other emergency, including evacuation of individuals receiving services.
(b) Posting of emergency information including, but not limited to, posting the following telephone numbers by designated telephones:
(A) Local fire, police department, and ambulance service, or "911".
(B) The executive director of the provider agency and other people to be contacted in case of emergency.
(c) A documented safety review must be conducted quarterly to ensure the service site is free of hazards. Safety review reports must be kept in a central location by a provider agency for three years.
(d) When an individual begins receiving services at a service site, a provider agency must deliver training to the individual to leave the site in response to an alarm or other emergency signal and to cooperate with assistance to exit the site.
(e) EVACUATION DRILLS. A provider agency must conduct an unannounced evacuation drill each month when individuals are present.
(A) Exit routes must vary based on the location of a simulated fire.
(B) Any individual failing to evacuate the service site unassisted within the established time limits set by the local fire authority for the site must be provided specialized training or support in evacuation procedures.
(C) Written documentation must be made at the time of the drill and kept by the provider agency for at least two years following the drill. The written documentation must include all of the following:
(i) Date and time of the drill.
(ii) Location of the simulated fire.
(iii) Last names of all individuals and staff present at the time of the drill.
(iv) Amount of time required by each individual to evacuate if the individual needs more than the established time limit.
(v) Signature of the staff conducting the drill.
(D) In sites delivering services to an individual who is medically fragile or has severe physical limitations, requirements of evacuation drill conduct may be modified. The modified plan must:
(i) Be developed with the local fire authority, the individual or the individual's legal or designated representative (as applicable), and the provider agency's executive director; and
(ii) Be submitted as a variance request according to OAR 411-450-0100.
(f) A provider agency must provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.
(g) HEALTH AND SAFETY INSPECTIONS. At least once every five years, a provider agency must conduct a health and safety inspection.

(A) The inspection must cover all areas and buildings where services are delivered to individuals, including administrative offices and storage areas.
(B) The inspection must be performed by:
(i) The Oregon Occupational Safety and Health Division;
(ii) The provider agency's worker's compensation insurance carrier;
(iii) An appropriate expert, such as a licensed safety engineer or consultant as approved by the Department; or
(iv) The Oregon Health Authority, Public Health Division, when necessary.
(C) The inspection must cover all of the following:
(i) Hazardous material handling and storage.
(ii) Machinery and equipment used at the service site.
(iii) Safety equipment.
(iv) Physical environment.
(v) Food handling, when necessary.
(D) The documented results of the inspection, including recommended modifications or changes and documentation of any resulting action taken, must be kept by the provider agency for five years.
(h) FIRE AND LIFE SAFETY INSPECTIONS. A provider agency must ensure each service site has received initial fire and life safety inspections performed by the local fire authority or a Deputy State Fire Marshal. The documented results of the inspection, including documentation of recommended modifications or changes and documentation of any resulting action taken, must be kept by the provider agency for five years.
(i) STAFFING. Direct service staff must be present in sufficient number to meet health, safety, and service needs specified in the individual ISP or Service Agreement for each individual present. When individuals are present, at least one staff member on duty must have the following minimum skills and training:
(A) CPR certification.
(B) Current First Aid certification.
(C) Training to meet other specific medical needs identified in individual ISPs or Service Agreements.
(D) Training to meet other specific behavior support needs identified in individual ISPs or Service Agreements.
(19) MEDICATIONS AND HEALTH AND MEDICAL NEEDS. A provider agency delivering services to individuals that involve assistance with meeting health and medical needs must:
(a) Develop and implement written policies and procedures addressing all of the following:
(A) Emergency medical intervention.
(B) Treatment and documentation of illness and health care concerns.
(C) Administering, storing, and disposing of prescription and non-prescription drugs, including self-administration.
(D) Emergency medical procedures, including the handling of bodily fluids.
(E) Confidentiality of medical records.
(b) Maintain a current written record for each individual receiving assistance with meeting health and medical needs that includes all of the following:
(A) Health status as known.
(B) Changes in health status observed during hours of service.
(C) Any remedial and corrective action required and when such actions were taken if occurring during hours of service.
(D) A description of any known restrictions on activities due to medical limitations.
(c) If providing medication administration when an individual is unable to self-administer medications and there is no other responsible person present who may lawfully direct administration of medications, the provider agency must:
(A) Have a written order or copy of the written order, signed by a physician or physician designee, before any medication, prescription or non-prescription, is administered.
(B) Administer medications per written orders.
(C) Administer medications from containers labeled as specified per physician written order.
(D) Keep medications secure and unavailable to any other individual and stored as prescribed.

(E) Record administration on an individualized Medication Administration Record (MAR), including treatments and PRN, or "as needed", orders.
(F) Not administer unused, discontinued, outdated, or recalled medication.
(G) Not administer PRN psychotropic medication. PRN orders may not be accepted for psychotropic medication.
(d) Maintain a MAR (if required). The MAR must include all of the following:
(A) The name of the individual.
(B) The brand name or generic name of the medication, including the prescribed dosage and frequency of administration as contained on physician order and medication.
(C) Times and dates the administration or self-administration of the medication occurs.
(D) The signature of the staff administering the medication or monitoring the self-administration of the medication.
(E) Method of administration.
(F) Documentation of any known allergies or adverse reactions to a medication.
(G) Documentation and an explanation of why a PRN, or "as needed", medication was administered and the results of such administration.
(H) An explanation of any medication administration irregularity with documentation of a review by the provider agency's executive director or their designee.
(e) Provide safeguards to prevent adverse medication reactions including, but not limited to, all of the following:
(A) Maintaining information about the effects and side-effects of medications the provider agency has agreed to administer.
(B) Communicating any concerns regarding any medication usage, effectiveness, or effects to an individual or the individual's legal or designated representative (as applicable).
(C) Prohibiting the use of one individual's medications by another individual or person.
(f) Maintain a record of visits to medical professionals, consultants, or therapists if facilitated or delivered by the provider agency.
(20) TRANSPORTATION. A provider agency that owns or operates vehicles that transport individuals must:
(a) Maintain the vehicles in safe operating condition.
(b) Comply with the laws of the Oregon Driver and Motor Vehicles Division (DMV).
(c) Maintain insurance coverage on the vehicles and all authorized drivers.
(d) Carry a first aid kit in each vehicle.
(e) Assign drivers who meet the applicable DMV requirements to operate vehicles that transport individuals.
(21) MANAGEMENT OF FUNDS. If assisting with management of funds, a provider agency must have and implement written policies and procedures related to the oversight of an individual's financial resources that includes the following:
(a) Procedures that prohibit inappropriately expending an individual's personal funds, theft of an individual's personal funds, using an individual's funds for the benefit of staff, commingling an individual's personal funds with the provider agency's or another individual's funds, or the provider agency becoming an individual's legal or designated representative.
(b) The provider agency's reimbursement to an individual of any funds that are missing due to theft or mismanagement on the part of any staff of the provider agency, or of any funds within the custody of the provider agency that are missing. Such reimbursement must be made within 10 business days of the verification that funds are missing.
(22) PROFESSIONAL BEHAVIOR SERVICES. A provider agency must have and implement written policies and procedures to assure professional behavior services are delivered by a qualified behavior professional in accordance with OAR chapter 411, division 304.
(23) BEHAVIOR SUPPORTS. A provider agency must have and implement written policies and procedures for the delivery of behavior supports that prohibits abusive practices and assures behavior supports are included in a Positive Behavior Support Plan.
(a) A provider agency must inform each individual, and as applicable their legal or designated representative, of the

behavior support policies and procedures at the time of entry and as changes occur.
(b) A decision to alter an individual's behavior must be made by the individual or their legal or designated representative.
(c) Psychotropic medications and medications for behavior must be:
(A) Prescribed by a physician through a written order; and
(B) Monitored by the prescribing physician for desired responses and adverse consequences.
(24) ADDITIONAL STANDARDS FOR BEHAVIOR SUPPORTS. For the purpose of this section, a designated person is the person implementing the behavior supports identified in an individual's Positive Behavior Support Plan.
(a) SAFEGUARDING INTERVENTIONS AND SAFEGUARDING EQUIPMENT.
(A) A designated person must only utilize a safeguarding intervention or safeguarding equipment when:
(i) BEHAVIOR. Used to address an individual's challenging behavior, the safeguarding intervention or safeguarding equipment is included in the individual's Positive Behavior Support Plan written by a qualified behavior professional as described in OAR 411-304-0150 and implemented consistent with the individual's Positive Behavior Support Plan.
(ii) MEDICAL. Used to address an individual's medical condition or medical support need, the safeguarding intervention or safeguarding equipment is included in a medical order written by the individual's licensed health care provider and implemented consistent with the medical order.
(B) An individual, or as applicable their legal representative, must provide consent for a safeguarding intervention or safeguarding equipment through an individually-based limitation in accordance with OAR 411-004-0040.
(C) Prior to utilizing a safeguarding intervention or safeguarding equipment, a designated person must be trained.
(i) For a safeguarding intervention, the designated person must be trained in intervention techniques using an ODDS-approved behavior intervention curriculum and trained to an individual's specific needs. Training must be conducted by a person who is appropriately certified in an ODDS-approved behavior intervention curriculum.
(ii) For safeguarding equipment, the designated person must be trained on the use of the identified safeguarding equipment.
(D) A designated person must not utilize any safeguarding intervention or safeguarding equipment not meeting the standards set forth in this rule even when the use is directed by an individual or their legal or designated representative, regardless of the individual's age.
(b) EMERGENCY PHYSICAL RESTRAINTS.
(A) The use of an emergency physical restraint when not written into a Positive Behavior Support Plan, not authorized in an individual's ISP, and not consented to by the individual in an individually-based limitation, must only be used when all of the following conditions are met:
(i) In situations when there is imminent risk of harm to the individual or others or when the individual's behavior has a probability of leading to engagement with the legal or justice system.
(ii) Only as a measure of last resort.
(iii) Only for as long as the situation presents imminent danger to the health or safety of the individual or others.
(B) The use of an emergency physical restraint must not include any of the following characteristics:
(i) Abusive.
(ii) Aversive.
(iii) Coercive.
(iv) For convenience.
(v) Disciplinary.
(vi) Demeaning.
(vii) Mechanical.
(viii) Prone or supine restraint.
(ix) Pain compliance.
(x) Punishment.
(xi) Retaliatory.

(25) AGENCY EMPLOYEES.

(a) A provider agency may not knowingly allow an agency employee to provide community living supports skills training or attendant care services, other than DSA or employment services, to an individual that also engages the agency employee's services as a personal support worker.

(b) A provider agency may not allow:

(A) The spouse of an individual receiving services to provide services as an employee of the agency to the employee's spouse.

(B) The parent of a minor child to provide services as an employee of the agency to the employee's own child unless:

(i) The child is enrolled in the Children's Extraordinary Needs Program; and

(ii) The parent provider and no other family member of the parent provider has an administrative role, leadership role, or ownership interest, in the provider agency.

(c) No later than January 1, 2023, a provider agency must only deliver community living supports through employees of the agency. Contracted direct support professionals are prohibited.

(26) PARENT PROVIDERS FOR THE CHILDRENS EXTRAORDINARY NEEDS PROGRAM.

(a) A provider agency must assure that a parent provider is in compliance with OAR chapter 411, division 440.

(b) A provider agency may not allow a child enrolled in the Children's Extraordinary Needs Program to receive more than a total of 20 hours of attendant care from one or more parent providers in a workweek, not to exceed the child's total monthly hour allocation as described in OAR 411-450-0060.

(c) A parent provider is not eligible to be paid using Department funds for attendant care delivered when any of the conditions in OAR 411-440-0050(2) are present.

(27) WAGES. A provider agency must maintain an average wage for direct support professionals who deliver hourly attendant care, not including DSA, that is equal to or greater than the hourly rate stated in the Department's approved published rate model.

(28) ANNUAL REPORTING. A provider agency must submit annual data to the nationally standardized reporting survey organization specified by the Department using the instructions provided by the organization and the Department.

STATUTORY/OTHER AUTHORITY: ORS 409.050, 427.024, 427.104, 430.662

STATUTES/OTHER IMPLEMENTED: ORS 409.010, 427.007, 427.024, 427.104, 427.181, 430.215, 430.610, 430.662