

State of Maine

12

DEPARTMENT OF LABOR

152

Bureau of Rehabilitation Services

Chapter 8

Rules Governing

Consumer Directed Personal Care Assistance Services

Effective Date: January 11, 2004

Maine Bureau of Rehabilitation Services

Consumer-Directed Personal Care Assistance Services

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DEPARTMENT OF LABOR

BUREAU OF REHABILITATION SERVICES

CHAPTER 8. CONSUMER-DIRECTED PERSONAL CARE ASSISTANCE SERVICES

PREAMBLE: These regulations are promulgated pursuant to 26 M.R.S.A. § 1412-G, relating to a program of consumer-directed personal care assistance services. It is the purpose of the Consumer-Directed Personal Care Assistance Services program to provide services, subject to the availability of funds, for adult Maine residents with severe disabilities that allow them to remain in their homes and communities and out of institutional settings. This program will strive to promote consumer choice, consumer direction, flexibility, as well as consumer responsibility in the provision of these services.

8.01 DEFINITIONS

- (A) **Consumer-Directed Personal Care Assistance Services** program, hereinafter referred to as **Consumer-Directed Home Based Care (CDHBC)**, is a state funded program to provide long term care services to assist eligible consumers to avoid or delay inappropriate institutionalization. State funds furnished through 26 M.R.S.A. § 1412-G may not be used to supplant the resources available from families, neighbors, agencies and/or the consumer or from other Federal, State programs unless specifically provided for elsewhere in this section. State HBC funds shall be used to purchase only those covered services that are essential to assist the consumer to avoid or delay inappropriate institutionalization and which will foster independence, consistent with the consumer's circumstances and the authorized plan of service.
- (B) **Activities of daily living (ADLs)** ADLs include the following as defined in Section 8.02(B)(1)(b): bed mobility, transfer, locomotion, eating, toileting, bathing, hygiene, and dressing. The list of ADLs may be modified by the Authorized Agency, with the approval of the Bureau.
- (C) **Assessing Services Agency (ASA)** ASA means an organization authorized through a written agreement with the Bureau of Rehabilitation Services (Bureau) to conduct face-to-face assessments, using the Bureau's Medical Eligibility Determination (MED) form, and the timeframes and definitions contained therein, to determine medical eligibility and need for covered services. Based upon a consumer's assessment outcome scores recorded in the MED form, the ASA is responsible for authorizing a plan of service, which shall specify all services to be provided under this Section, including the number of hours for services, and the Authorized Agent types. The ASA is the Bureau's Authorized Agent for medical eligibility determinations and service plan development, and authorization of covered services as allowed under this Section.

- (D) **Authorized Agent** means an organization authorized by the Bureau to perform functions under a valid contract or other approved, signed agreement. Authorized Agent (AA) means an organization, through a written contract with the Bureau, to conduct a range of activities, which includes some or all of the following: accept referrals; assess consumer service needs; monitor the implementation of the service plan; train the consumer; serve as a resource to consumers and their families; and assist with resolving problems. The Authorized Agent is also responsible for administrative functions, including maintaining consumer records; processing claims; final determination of the consumer copayment on receipt of the required information and collection of consumer co-payments; conducting the functions of an employer of record; and conducting required utilization review activities.
- (E) **Authorized Plan of Service** is a plan of service that is determined by the Assessing Services Agency, or the Bureau, and that specifies all services to be delivered to a consumer as allowed under this Section, including the number of hours for all covered services under this section. The Authorized Plan of Service shall be based upon the consumer's assessment outcome scores, and the timeframes contained therein, recorded in the Bureau's medical eligibility determination (MED) form. The Authorized Plan of Service must be completed on the Bureau's MED form and must not exceed the services required to provide necessary assistance with ADLs, IADLs, and identified Health Maintenance Activities on the MED form. The Authorized Agent has the authority to determine and authorize the plan of service. All authorized covered services provided under this Section must be listed in service Plan summary on the MED form. The Authorized Plan of Service must reflect the needs identified by the assessment, giving consideration to the consumer's living arrangement, informal supports, and services provided by other possible public or private funding sources to ensure non duplication of services.
- (F) **Bureau** means the Bureau of Rehabilitation Services.
- (G) **Service Plan Summary** is the section of the MED form that documents the Authorized Plan of Service and services provided by other public or private program funding sources or support, service category, reason codes, duration, unit code, number of units per month, rate per unit, and total cost per month.

- (H) **Cognitive capacity:** The consumer must have the cognitive capacity to perform all of the tasks and responsibilities of an employer in order to competently direct and manage the assistant. The consumer's cognitive capacity will be determined by an assessment conducted by the Authorized Agency.
- (I) **Complete Medical Eligibility Determination packet** includes a signed release of information, the fully completed medical eligibility determination (MED) form, the eligibility notification, hearing and appeal rights, service plan, complete financial assessment. Packets submitted that do not meet Bureau specifications will be returned to the AA.
- (J) **Consumer**, is the individual qualified for the program who will direct and control the PCA. The consumer is someone with a disability who has functional limitations, which interfere with self-care and activities of daily living. The consumer must have the cognitive capacity to competently direct and manage the assistant on the job in order to assist and/or perform the ADLs, IADLs, and health maintenance activities. The consumer must be determined eligible for services under this section.
- (K) **Consumer-Directed Home Based Care Services**, also known Personal Assistance Services (PAS), or Assistance Services, enable eligible people with disabilities to re-enter or remain in the community and to maximize their independent living opportunity at home. Consumer Directed Home Based Care Services includes a range of assistance with Activities of Daily Living (ADL), Instrumental Activities of Daily Living and Health Maintenance activities. The eligible consumer hires his/her own assistant, trains the assistant, supervises the provision of covered services, completes the necessary written documentation, and if necessary, terminates services or directs the termination of the assistant. The Bureau of Rehabilitation Services (Bureau) or its Authorized Agent, consistent with these rules, shall determine medical eligibility for services under this Section, prior authorize all covered services as allowed under this section, and authorize a plan of service for each new and established consumer of services.

- (L) **Covered Services** are those services for which payment can be made by the Bureau, under Section 8 of the Bureau of Rehabilitation Services regulations.
- (M) **Criminal Background Check** is research into the history of a PCA or potential PCA to determine if there is any criminal convictions involving abuse, neglect or misappropriation of property in a health care setting, or a complaint involving abuse or neglect that was substantiated by the Department of Human Services pursuant to its responsibility to license hospitals, nursing facilities, home health agencies and assisted housing programs and that was entered on the Maine Registry of Certified Nursing Assistants, or a complaint involving the misappropriation of property in a health care setting that was substantiated by the Department of Human Services and entered on the Maine Registry of Certified Nursing Assistants.
- (N) **Department** means the Maine Department of Labor.
- (O) **Dependent Allowances.** Dependents and dependent allowances are defined and determined in agreement with the method used in the MaineCare program. The allowances are changed periodically and cited in the Maine Medical Eligibility Manual, Chart II, AFDC Related Income Limits. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the consumer or consumer's spouse. A spouse may not be included.
- (P) **Disability-related expenses:** Disability-related expenses are out-of-pocket costs incurred by the consumers for their disability, which are not reimbursed by any third-party sources. They include:
- (1) Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening, environmental controls;
 - (2) Communication devices: adaptations to computers, speaker telephone, TTY, Personal Emergency Response Systems;
 - (3) Wheelchair (manual or power) accessories: lap tray, seats and back supports;
 - (4) Vehicle adaptations: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving;
 - (5) Hearing Aids, glasses, adapted visual aids;
 - (6) Assistive animals (purchase only);

- (7) Physician ordered medical services and supplies;
 - (8) Physician ordered prescription and over the counter drugs;
 - (9) Medical insurance premiums, co-pays and deductibles;
 - (10) Unemployment and workers compensation expenses related to employing the PCA, ; and
 - (11) The actual paid costs of conducting criminal background checks
- (Q) **Extensive Assistance** means although the individual performed part of the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was required and provided:
- (1) Weight-bearing support three or more times, or
 - (2) Full staff performance during part (but not all) of the last 7 days.
- (R) **Health Maintenance Activities** are those activities designed to assist the consumer with ADLs and IADLs and additional activities as specified in the definition. These activities are performed by a designated individual who provides formal and informal supports for a competent self-directing individual, who would otherwise perform the activities, if he or she were physically able to do so and enable the individual to live in his or her own home and community. These additional activities include catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, ventilator care, occupational and physical therapy activities such as assistance with prescribed exercise regimes.
- (S) **Income** includes:
- (1) Wages from work, including payroll deductions, excluding state and Federal taxes and employer mandated or court ordered withholdings;
 - (2) Benefits from Social Security, Supplemental Security Insurance, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;
 - (3) Adjusted gross income from property and/or business, based on the consumer's most recent Federal income tax; and
 - (4) Interest and dividends.

Not included are benefits from: the Home Energy Assistance Program, Food Stamps, General Assistance, Property Tax and Rent Refund, emergency assistance programs, or their successors.

- (T) **Instrumental activities of daily living (IADLs)** Instrumental Activities of Daily Living (IADL); For purposes of the eligibility criteria and covered services under this section of policy, IADLs are limited to the following: meal preparation: preparation or receipt of the meal; routine housework; grocery shopping, storage of purchased groceries; community access; and laundry either within the residence or at an outside laundry facility; and money management, as directed by the consumer, for the consumer. The list of IADLs may be modified by the PASCA, with the approval of the Bureau.
- (U) **Limited Assistance** means the individual was highly involved in the activity over the past seven days, or 24 to 48 hours if in a hospital setting, but received and required guided maneuvering of limbs or other non-weight bearing physical assistance three or more times or with weight-bearing support one or two times.
- (V) **Liquid asset** is something of value available to the consumer that can be converted to cash in three months or less and includes:
- (1) Bank accounts;
 - (2) Certificates of deposit;
 - (3) Money market and mutual funds;
 - (4) Life insurance policies;
 - (5) Stocks and bonds; and
 - (6) Lump sum payments and inheritances.
 - (7) Funds from a home equity conversion mortgage that are in the consumer's possession whether they are cash or have been converted to another form. Funds which are available to the consumer but carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide income as a replacement for earned income. The income from these payments will be counted as income.
- (W) **Personal Assistance needs** are those determined as a result of completion of the medical eligibility determination form, resulting from an individual's inability to manage ADLs and IADLs, as a result of physical, emotional, or developmental problems.
- (X) **Medical Eligibility Determination (MED) Form** is the form approved by the Bureau for medical eligibility determinations and service authorization for the Authorized Plan of Service based upon the assessment outcome scores. The definitions, scoring mechanisms and time-frames-relating to this form are contained therein and provide the basis for services and the service plan

authorized. The service plan summary contained in the MED form documents the Authorized Plan of Service approved by the Authorized Agent. It also includes the service category, reason codes, duration, unit codes, number of units per month and rate per unit.

- (Y) **Multi-disciplinary team (MDT).** The MDT includes the consumer, the Authorized Agency designated Registered Nurse (RN), Occupational Therapist (OT), or Certified Occupational Therapy Aid (COTA) staff, and may also include other people who provide or have an interest in the consumer's services. An OT will review and sign off on the work of COTA staff.
- (Z) **One-person Physical Assist** requires one person over last seven (7) days or 24-48 hours if in a hospital setting, to provide either weight-bearing or non-weight bearing assistance for an individual who cannot perform the activity independently. This does not include cueing.
- (AA) **Personal Assistance Services** are services provided by a personal care assistant (PCA), which are required by an adult with personal care needs to achieve greater physical independence, which are consumer directed and which are limited to assistance with:
- (1) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;
 - (2) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
 - (3) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
 - (4) Eating: How person eats and drinks (regardless of skill);
 - (5) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
 - (6) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower;
 - (7) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing.
 - (8) Hygiene: How person combs hair, brushes teeth, shaves, applies make-up, and washes and dries one's face and perineum.
- (BB) **Provider Agency** is the organization responsible for the implementation on the Plan of Service, case management functions, record keeping, training of consumers, and fiduciary duties as outlined in the contract with the Bureau.
- (CC) **Quality assurance review committee (QARC)** is a group appointed by the Bureau of Rehabilitation Services, whose responsibility it is to make recommendations to the Bureau for policy changes and improving quality of care and outcomes for the consumer.

- (DD) **Self-Direct** means the consumer hires, trains, directs assistants, and when necessary terminates the assistant. The applicant's ability to self-direct must be documented on the Medical Eligibility Determination Form.
- (EE) **Service Plan** is the document used by the Authorized Agency to assist the consumer to direct their assistant services as specified in the authorized plan of service. The Bureau must approve the service plan in template form. The plan must outline the ADL and IADL tasks, the time required to complete the tasks, and the frequency of the tasks that will be the basis for the assistant's job description and weekly schedule. The service plan will show the total hours available each week for the consumer to manage and direct the assistant. The hours shall not exceed the hours authorized on the MED form service plan summary and must include only the covered services from Section 8.04. The service plan is prepared after and is based on the completed MED form.
- (FF) **Significant change.** A significant change is defined as a major change in the consumer's status that, impacts on one or more areas of their functional or health status, and requires review or revision of the plan of service. A significant change assessment is appropriate if there is a consistent pattern of changes, with either two or more areas of improvement, or two or more areas of decline, that requires a review of the service plan and potential for a level of care change.
- (GG) **Total Dependence** means full staff performance of the activity during the last seven (7) day period across all shifts, or during each eight (8) hour period in the twenty-four (24) hours.

8.02 ELIGIBILITY FOR SERVICES

- (A) **General and Specific Requirements.** To be eligible for services a consumer must:
- (1) Be at least 18;
 - (2) Live in Maine; "Live in Maine" means to have legal residence in Maine and be present in Maine for 183 days of the year, except for Maine resident students attending school. Consumers relocating may be allowed up to one month's program services to assist the consumer to make a transition to other services;
 - (3) Lack sufficient personal and/or financial resources for in-home services;
 - (4) Be ineligible for the MaineCare Private Duty Nursing Personal Assistance Services, , MaineCare Adult Day Health, MaineCare Consumer Directed Assistant Services programs. Consumers who are eligible for the Medicaid Home and Community Based Waiver program may be deemed eligible for supplemental funds under this program, subject to availability of funds;
 - (5) Not be residing in a hospital or nursing facility;
 - (6) Agree to pay the monthly calculated consumer payment. This payment may be subsequently waived or reduced if the consumer's application for a waiver or reduction is approved.
 - (7) Not have a guardian or a conservator:

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- (8) Eligibility for the Consumer Directed HBC Program requires a significant level of skill and responsibility from the consumer. In order to be eligible for HBC services, a consumer must be capable of performing all the tasks and responsibilities of an employer. In order to best determine the applicant's ability to function in this role, the Authorized Agent will assess the individual's cognitive abilities as follows:
- (A) Based on actual performance during skills training. The assessor will review the consumer's ability to understand and retain the elements included in the regular course of consumer skills training.
 - (B) In actual performance as a consumer of program services. During the course of using program services, and particularly during the first year of service, the Authorized Agent will continually assess the consumer's ability to successfully participate in the Program. Included in skills training will be:
 - (1) Understanding of the consumer's disability , including health issues and relevant adaptive equipment and ability to explain disability to others
 - (2) Ability to understand and communicate assistance needs
 - (3) Ability to understand and communicate safe and unsafe conditions
 - (4) Ability to handle finances associated with the program
 - (5) Ability to communicate effectively in writing, verbally or using adaptive equipment
 - (6) Demonstrated ability to direct others as needed in an employment relationship
 - (7) Ability to create and carryout daily work plans for PCAs
 - (8) Understanding of local resources and ability to self refer for needed services
 - (9) Demonstrated ability to create and carryout a hire plan for PCAs
 - (10) Ability to train and supervise PCAs
 - (11) Ability to retain PCAs as employees
 - (12) Ability to successfully carry out the responsibilities of program consumers as specified in the Bureau of Rehabilitation Services' rules governing the Home Based Care Program.
 - (13) Demonstrated understanding of HIPAA confidentiality requirements

At any point during the initial evaluation, or in the course of ongoing service, that the Authorized Agent determines the consumer is unable to carryout the requirements of this section, the consumer will be found ineligible for the program.

- (9) The individual must agree to undergo consumer instruction and testing within thirty (30) days of the assessment in order to develop and verify that they have

attained the skills needed to hire, train, schedule, supervise, and document the provision of Personal Assistance Services identified in the authorized plan of service. Consumers who do not complete the instruction or do not demonstrate to the Authorized Agent that they have attained the skills needed to hire, fire, train, schedule, supervise and document the delivery of their identified care services, are not eligible for services under this Section;

- (10) The consumer may not reside in a licensed residential setting. The individual's residence, while using Consumer Directed Home Based Care Services, may be the individual's home or a transitional living program. Personal Assistance Services cannot be delivered in an Adult Family Care Home (AFCH) setting or other licensed Assisted Living Facility which is currently reimbursed by state and /or federal funds for providing personal care services; and
- (11) If the assessment for continued eligibility indicates medical eligibility for a MaineCare program and potential financial eligibility for MaineCare, consumers will be given written notice that the consumer has up to thirty (30) days to file a MaineCare application. If Personal Assistance Services are currently being received, services shall be discontinued if a Bureau of Family Independence notice is not received within thirty (30) days of the assessment date indicating that a financial application has been filed. Services shall also be discontinued if, after filing the application within thirty (30) days the application requirements have not been completed in the time required by MaineCare policy.

(B) Medical and Functional Eligibility Requirements

- (1) A person meets the medical eligibility requirements for Consumer Directed Home Based Care if he or she requires limited assistance plus a one person physical assist with at least two (2) ADLs, the sum of the ADLs equaling 16 or more hours per week, from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing
 - (a) **Activities of Daily Living:**
 - (a) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;
 - (b) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
 - (c) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
 - (d) Eating: How person eats and drinks;
 - (e) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
 - (f) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower; and

- (g) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.
- (2) Must have the cognitive capacity, measured on the MED form, as defined in Section 8.01, to be able to direct the services. The Authorized Agent as part of the assessment will determine this capability;
- (3) The individual must agree to complete initial consumer instruction and testing within thirty (30) days of date of the completion of the MED form to determine medical eligibility in order to develop and verify that they have attained the skills needed to hire, train, schedule and supervise assistants, and document the provision of personal assistance services identified in the Authorized Plan of Service. Consumers who do not complete the course of instruction or do not demonstrate to the Authorized Agency they have attained the skills needed to hire or select, fire, and train assistants, schedule, supervise and document the delivery of their identified care services, are not eligible under this section.

8.03 DURATION OF SERVICES

Each Consumer Directed Home Based Care consumer may receive as many covered services as identified, documented and authorized on the MED form, as required, within the limitations and exceptions described below. Home Based Care coverage of services under this Section requires prior authorization from the Bureau or its Authorized Agent. Beginning and end dates of an individual's medical eligibility determination period correspond to the beginning and end dates for Home Based Care coverage of the plan of service authorized by the Authorized Agent or the Bureau. The services provided must be reflected in the Service Plan and based upon the authorized covered services documented in the care plan summary of the MED form.

- (A) The total monthly cost of services may not exceed the lesser of the monthly plan of service authorized by the Authorized Agent or the monthly cap, established by the Bureau.
- (B) Suspension. Services will be suspended if the consumer is hospitalized or using institutional care. If such circumstances extend beyond thirty (30) days the consumer must be reassessed to determine appropriate services. Upon discharge from a hospital or institutional care facility, the consumer's previous level of service will resume until a reassessment is conducted. The reassessment will be conducted within two weeks following the consumer's discharge from the hospital or institutional care facility.
- (C) Services under this Section may be suspended, reduced, denied or terminated by the Bureau or the Authorized Agent, as appropriate depending on the nature and severity of the situation, for the following reasons:
 - (1) The consumer does not meet eligibility requirements;

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- (2) The consumer declines services;
- (3) The consumer is eligible to receive services under a MaineCare program, including any MaineCare Home or Community Based waiver program or a State funded long term care services program;
- (4) Based on the consumer's most recent MED assessment, the plan of service is reduced to match the consumer's needs as identified in the reassessment and subject to the limitations of the program cap;
- (5) The health or safety of the consumer or of individuals providing services is endangered;
- (6) Consumer refuses personal assistance services;
- (7) Consumer has failed to make his/her calculated monthly co-payment within thirty (30) days of receipt of the co-pay bill;
- (8) When the consumer gives fraudulent information, including, but not limited to assessment information and reporting, payroll records, and all other recording keeping documents to the Bureau of Rehabilitation Services or the Authorized Agent;
- (9) The consumer fails to personally manage an assistant;
- (10) The consumer is using program funds to pay the personal care assistant to complete tasks outside the covered services in Section 8.04;
- (11) Failure of a consumer to demonstrate the skills necessary to successfully manage his/her personal-health maintenance, including management of the PCA in compliance with these rules;
- (14) The consumer endorses or attempts to endorse a check that is made payable to the PCA;
- (15) The consumer fails to carryout his/her responsibilities for FICA withholding, unemployment insurance or worker's compensation insurance;
- (16) In the event that a consumer is found to have used program funds in violation of the requirements of this section, the consumer must reimburse the Authorized Agent for all such funds before being subsequently considered for services under this Chapter.
- (17) In the event that services have been denied or terminated by the Authorized Agent or the BRS for any of the reasons included in this section, such actions will be a factor in determining eligibility in any subsequent application for services under this rule.

Notice of intent to reduce, deny, or terminate services under this section will be done in accordance with (A) of Section 8.14 of this Policy Manual.

8.04 COVERED SERVICES

Covered services are available for individuals meeting the eligibility requirements set forth in Section 8.02. All covered services require prior authorization by the Bureau, or its Authorized Agent, consistent with these rules, and are subject to the limits in Section 8.03. The Authorized Plan of Service shall be based upon the consumer's assessment outcome scores recorded on the Bureau's Medical Eligibility Determination (MED) form, and its definitions.

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Services provided must be required for meeting the identified needs of the individual, based upon the outcome scores on the MED form, and as authorized in the plan of service. Coverage will be denied if the services provided are not consistent with the consumer's authorized plan of service. The Bureau may also recoup payment from the Authorized Agency for inappropriate service provision, as determined through post payment review.

Covered Services are:

- (A) Administration** Costs of the overall administration of this program are built into the hourly rate for Personal Assistance Services. Tasks required by the Authorized Agent for overall administration include consumer assessment, monitoring, assistance, instruction, and assistant payment processing. Such tasks include:
- (1) initial eligibility assessments and re-assessments to determine medical eligibility and the consumer's ability to self-direct;
 - (2) determining the need for additional non-scheduled reassessments or additional skills training;
 - (3) providing skills training and testing;
 - (4) monitoring, through face-to-face contact, unless the consumer has previous experience with another personal assistance program, at least twice in the first six (6) months and annually thereafter to coincide with reassessment, documenting and taking appropriate action concerning any changes in the general health and welfare of the consumer;
 - (5) providing consumer instruction services as needed by the individual consumer to demonstrate competency in the direction and management of the PCA for initially instructing the consumer in the management of personal care assistants and additional instruction as needed.
 - (a) Consumer instruction services must be provided to each new eligible consumer prior to the start of services. The Authorized Agent must document that the consumer has successfully completed the training within thirty (30) calendar days of the date of determination of medical eligibility.
 - (b) Instruction in PCA management includes: instruction in recruiting, interviewing, selecting, training, scheduling and directing a competent assistant in the activities identified in the authorized plan of service and if necessary terminating the PCA's employment.
 - (c) Consumer instruction also includes instructing the consumer in his or her rights and responsibilities, including the obligations under the Consumer Directed Home Based Care policy.
 - (6) assessing the consumer/ assistant relationship, including whether assistant duties are being performed satisfactorily, whether assistant training is adequate or if additional training is needed;
 - (7) issuing a "notice of intent to reduce, deny or terminate Home Based Care services" as defined and applicable in Section 8.03.
- (B) Consumer Directed Personal Assistance Services**
Consumers who qualify for Assistance Services are eligible for the following services:

- (1) Bed mobility, transfer, and locomotion activities to get in and out of bed, wheelchair or motor vehicle;
 - (2) Using the toilet and maintaining continence;
 - (3) Health maintenance activities as defined in 8.01 (Q)
 - (4) Bathing, including transfer;
 - (5) Personal hygiene which may include combing hair, brushing teeth, shaving, applying makeup, washing and drying face, hands, and perineum;
 - (6) Dressing;
 - (7) Eating, and cleanup;
 - (8) Household tasks for the consumer only, when authorized and specified in the Authorized Plan of Service. These tasks must be furnished in conjunction with direct service to the consumer and directed by the consumer;
 - (a) grocery and prepared food shopping, assistance with obtaining medication, to meet the consumer's health and nutritional needs;
 - (b) routine housework, including sweeping, washing and/or vacuuming of floors, cleaning of plumbing fixtures (toilet, tub, sink), appliance care, changing of linens, refuse removal;
 - (c) laundry done within the residence or outside of the home at a laundry facility;
 - (d) money management, as directed by the consumer, for the consumer, and
 - (e) meal preparation and clean up.
 - (9) Consumers who need assistance during their regular sleep hours may receive a stipend for services for a set rate per twenty-four hour period to be determined by the Bureau and the Authorized Agent. Regular hours, as determined by the assessment, may also be used at any time to meet any additional needs of the consumer.
- (C) Transportation.** Transportation services may be provided only when a consumer is unable to be transported alone. Consumers shall first attempt to locate other resources before utilizing transportation services under this program. Travel time of the assistant shall be assessed only in the course of delivering a covered service and in support of IADLs as determined during the assessment. Additional time for transportation may not be added to the plan of service. A consumer may, however, substitute their existing hours of other activities necessary for independent living for transportation time. Any individual providing transportation must hold a valid State of Maine driver's license for the type of vehicle being operated. All Authorized Agents of transportation services shall maintain adequate liability insurance coverage for the type of vehicle being operated
- (D) Personal Emergency Response System (PERS).** A Personal Emergency Response System is an electronic device which enables individuals to secure help in the event of an emergency. PERS services may be authorized for individuals who live alone, or who are alone for significant parts of the day, who are capable of using the system, and have no regular assistant for extended periods of time, and who would otherwise require extensive

routine supervision. The use of the PERS will result in a reduction of authorized hours that are equal to the cost of the service.

8.05 NON COVERED SERVICES

The Following services are not reimbursable under this Section:

- (A) Rent and food
- (B) Services for which the cost exceeds the limits described in Section 8.03;
- (C) Personal assistance services (defined in 8.01(Z)) delivered in an Adult Family Care Home setting or other licensed Assisted Living Facility which is reimbursed for providing personal assistance services;
- (D) Services provided by a personal care assistant who is not found to be employable under the criminal background check requirements of the Maine Registry of Certified Nursing Assistants.
- (E) Homemaker and handyman/chore services not directly related to medical need;
- (F) Those services which can be reasonably obtained by the consumer by going outside his/her place of residence;
- (G) Travel time and mileage by the Authorized Agent, Authorized Agent's staff, and/or the assistant to and from the consumer's residence;
- (H) Mileage for personal care assistants.
- (I) Household tasks except when delivered as an integral part of the Authorized Plan of Service as described in Section 8.04;
- (J) Custodial, supervisory or respite care;
- (K) Off-site services, except in the provision of covered IADLs
- (L) On call services

8.06 POLICIES AND PROCEDURES

(A) Eligibility Determination

An eligibility assessment, using the Bureau's approved Medical Eligibility Determination (MED) form, shall be conducted by the Bureau or the Authorized Agent. All Home Based Care services require an eligibility determination and prior authorization by the Authorized Agent to determine eligibility pursuant to Section 8.02.

- (1) The Authorized Agent will accept verbal or written referral information on each prospective new consumer, to determine appropriateness for an assessment. When funds are available to conduct assessments, prospective consumers will receive a face to face medical eligibility determination assessment at their current residence within fifteen (15) business days of the date of referral to the Authorized Agent. All requests for assessments shall be documented indicating the date and time the assessment was requested and all required information provided to complete the request. The individual conducting the assessment shall be a Registered Nurse (RN), occupational therapist (OT) or a certified occupational therapy aid (COTA), whose work will be reviewed and signed off by an OT, and will be trained in conducting assessments and developing an authorized plan of service with the Bureau's approved MED tool. The assessor's findings and scores recorded in the MED form shall be the basis in establishing eligibility for services and the authorized plan of service. The anticipated costs of covered services to be provided under the authorized plan of service must conform to the limits set forth in Section 8.03(A).
- (2) The Authorized Agent shall inform the consumer of available community resources and authorize a plan of service that reflects the identified needs documented by scores and timeframes on the MED form, giving consideration to the consumer's living arrangement, informal supports, and services provided by other public and private funding sources. CDHBC services provided to two or more consumers sharing living arrangements shall be authorized by the Authorized Agent with consideration to the economies of scale provided by the group living situation, according to limits in Section 8.03. The Authorized Agent shall authorize a plan of service based upon the scores and findings recorded in the MED assessment. The covered services to be provided in accordance with the authorized plan of service shall: 1) not exceed the lesser of the monthly plan of service authorized by the Authorized Agent or the financial cap established by Bureau of Rehabilitation Services; and 2) be prior authorized by the Bureau or its Authorized Agent. The assessor shall approve an eligibility period for the consumer, based upon the scores and needs identified in the MED assessment and the assessor's clinical judgment. (3) The assessor will provide a copy of the authorized service plan, in a format understandable by the average reader and approved by the Bureau, a copy of the eligibility notice, release of information and the appeal hearing rights notice, to the consumer at the completion of the

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assessment. The assessor will inform the consumer of the estimated co-payment and the cost of services authorized.

- (4) The assessor shall forward the fully completed assessment packet to the Bureau within five (5) business days of the medical eligibility determination and authorization of the plan of service. The Bureau will not approve eligibility or payment without a fully completed assessment.
- (5) The Authorized Agent will complete initial skills training within thirty (30) days of the date of the completion of the medical eligibility determination form. Payment of Consumer Directed services can begin only after the Bureau is notified that the consumer has successfully completed this training and the complete medical eligibility packet has been received.

(B) Waiting List

- (1) Consumers will be assessed on a first come, first served basis.
- (2) For consumers found ineligible for CDHBC services the Authorized Agent will inform each consumer of alternative services or resources, and offer to refer the person to those other services.
- (3) When funds are not available to serve new consumers, or to increase needed services to current consumers, a waiting list will be established by the Bureau in consultation with the Authorized Agent. Individuals on the waiting list will be interviewed by the Authorized Agent by phone for a pre-admission screening to determine their potential eligibility. As funds become available consumers will be taken off the list, fully assessed, and served on a first come, first served basis.
- (4) When there is a waiting list, the Authorized Agent will inform each consumer who is placed on the waiting list of alternative services or resources, and offer to refer the person to those other services.
- (5) The Authorized Agent will maintain one statewide waiting list.
- (6) The Authorized Agent must suspend services if the consumer is hospitalized or using institutional care. If such circumstances extend beyond thirty (30) days, the consumer participation in the program will be suspended, and the consumer will be reassessed to determine medical eligibility for these services. Consumers will continue to receive their prior level of service until a reassessment is completed. The reassessment will be conducted within two weeks following the consumer's discharge from the hospital or institutional care facility.

(C) Reassessment and Continued Services

- (1) For all consumers under this section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and prior authorization of services is required and must be conducted within the timeframe of 15 days prior to and no later than the reassessment due date. HBC payment ends with the reassessment date, also known as the end date.
- (2) The Authorized Agent shall review, face-to-face, with the consumer, at the consumer's residence, the medical eligibility for services at least twice during the first six months the consumer received services under this section and at least annually thereafter, or when there is a significant change as defined in 8.01(DD). The agent shall provide consumer instruction services as needed by the individual

consumer to demonstrate competency in the direction and management of the PCA for initially instructing the consumer in the management of personal care assistants and additional instruction as needed.

- (3) Significant change reassessments will be requested by the consumer. According to the definition in Section 8.01(DD) the Authorized Agent will review the request and the most recent assessment to determine whether a reassessment is warranted and has the potential to change the level of service or alter the authorized plan of service.
- (4) For consumers currently under the appeal process, reassessments will not be conducted unless the consumer experiences a significant change as defined in Section 8.01(DD) or no longer has the ability to self direct as defined in Section 8.01 (BB).

8.07 PROFESSIONAL AND OTHER QUALIFIED STAFF

(A) Registered Professional Nurse

A registered professional nurse employed directly or through a contractual relationship or acting as an individual practitioner may provide services by virtue of possession of a current license to practice their health care discipline in the State in which the services are performed.

(B) Occupational Therapist

An occupational therapist must be licensed to practice occupational therapy by the Maine Board of Occupational Therapy Practice, as documented by written evidence from such Board.

(C) Certified Occupational Therapy Assistant (COTA) An Occupational Therapy

Assistant who is licensed to practice occupational therapy in the State of Maine, under the documented (co-signed) supervision of a licensed occupational therapist.

(D) Assistants

Assistants must be at least 16 years old have the ability to assist with activities of daily living as defined in Section 8.04. Consumers are responsible for complying with all state and federal child labor laws relating to Assistants under 18 years old. An assistant cannot be an individual who has a notation on the Maine Registry of Certified Nursing Assistants as stipulated in 8.01 (L) of these rules.

After the completion of the consumer's skills training, the consumer trains the assistant on the job. Within a twenty-one (21) day probation period, the consumer will determine the competency of the assistant on the job. At a minimum, based upon the assistant's job performance, the consumer will certify competence in the following areas:

- (a) ability to follow oral, or signed, and written instructions and carry out tasks as directed by the consumer;
- (b) disability awareness;
- (c) use of adaptive and mobility equipment; transfers and mobility; and

- (e) ability to assist with activities of daily living and health maintenance activities.

Satisfactory performance will result the consumer completing a PCA competency form. This statement is signed by the consumer, submitted to the AA, and a copy is kept in the consumer's record.

8.08 PROGRAM RESPONSIBILITIES

(A) Consumer Control and Responsibility

- (1) Employment of Personal Care Assistant. The consumer must control and direct the PCA in the selection, hiring, management, training, scheduling, and, when necessary, termination of his or her PCA. The consumer shall accept personal responsibility for all of the requirements listed below relating to his or her PCA, including:
 - (a) Hiring, training, supervision, and termination of the PCA or directing the AA in selection, supervision and termination;
 - (b) Establishing work schedules ;
 - (c) Carrying out the plan of service as it relates to the PCA and using the PCA responsibly;
 - (d) Unemployment and workers compensation insurance, unless the consumer has chosen to have this carried out by the AA ; and
 - (e) Maintaining records, which comply with Maine State employment laws.
- (2) Payroll reports. Consumers shall submit payroll reports, including W-2 and W-4 forms, as required by the established payroll procedures and schedules as determined by the Bureau and Authorized Agent.
- (3) PCA Documentation. The consumer must file with the Authorized Agent at least two copies of documents used during the hiring process to determine identification and employment status. Such documents will be those that meet the requirements of the Employment Eligibility Verification Form of the U.S. Department of Justice, commonly known as the I-9 Form
- (4) Department Requests. Consumers shall provide all information requested by the Department, including surveys of the program for evaluation and planning purposes.
- (5) Compliance with Applicable Laws. Consumers shall comply with all federal and state laws relating to child labor and employment relationships, including but not limited to, matters relating to hiring, benefits, conditions of work, and terminations.
- (6) Notice of Change. Consumers shall notify the Authorized Agent as soon as possible about any of the following matters:
 - (a) Changes in name, address, telephone number, personal care assistant, amount of PCA services needed, guardianship, agent, or designee, if any;
 - (b) Plans to leave the state or actual absences from the State in excess 183 days during the year;
 - (c) Hospitalization;
 - (d) Any institutional stays where assistant services are available to the consumer;
 - (e) Changes in MaineCare eligibility;
 - (f) Changes in the type or amount of assistance services received through another source or program;

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- (g) Changes in need for assistant services including changes in disability, medical condition, or living situation which substantially affect the need for assistant services; and
 - (h) Any other changes in their eligibility as referenced in Section 8.02 Eligibility for Services or Section 8.03 Duration of Services.
- (7) Assistants Under the Age of Eighteen (18). All Personal Care Assistants under the age of eighteen (18) must report their age and social security number to the Authorized Agent. Personal Care Attendants must be at least 16 years of age.

(B) Responsibilities of the Bureau of Rehabilitation Services

- (1) Selection of Authorized Agent. To select authorized agencies, the Bureau of Rehabilitation Services will request proposals at least every three (3) years by publishing a notice in Maine's major daily newspapers and posting on the Bureau of Rehabilitation Services website. The notice will summarize the detailed information available in a request for proposals (RFP) packet and will include the name, address, and telephone number of the person from whom a packet and additional information may be obtained. The packet will describe the specifications for the work to be done. Criteria used in selection of the successful bidder or bidders will include but are not necessarily limited to:
- (a) Cost;
 - (b) Organizational capability;
 - (c) Response to a sample case study;
 - (d) Qualifications of staff;
 - (e) References;
 - (f) Quality assurance plan;
 - (g) Ability to comply with applicable program policies;
 - (i) Demonstrated experience; and
 - (ii) Understanding of disability and independence issues of consumers.
- (2) Other Responsibilities of the Bureau of Rehabilitation Services. Bureau of Rehabilitation Services is responsible for:
- (a) Setting the annual individual service plan cost limit.
 - (b) Establishing performance standards for contracts with authorized agencies including but not limited to the numbers of consumers to be assessed and served and allowable costs for administration and direct service.
 - (c) Conducting or arranging for quality assurance reviews that will include record reviews and home visits with CDHBC consumers.
 - (d) Establishing and maintaining regional quality assurance review committees (QARC).
 - (i) The QARC is responsible for:
 - (a) Making recommendations for policy changes to the Authorized Agent and Bureau of Rehabilitation Services;
 - (b) Make recommendations for improving quality of care and outcomes for the consumer. The QARC may review; the Bureau's Quality Assurance data and reports;

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- (c) Meeting as often as necessary, but at least four times annually;
- (d) Using procedures that ensure consumer confidentiality.
- (ii) The QARC shall have at least six (6) members. The Bureau of Rehabilitation Services is responsible for scheduling, notifying and recruiting new members, and documenting and distributing the meeting minutes and case review summaries to all members.
Membership on the QARC must include:
 - 1. The home care coordinating staff;
 - 2. The assessing services agency staff;
 - 3. Service Authorized Agents;
 - 4. A representative of the Consumer Advisory Committee;
 - 5. Agencies/organizations that have an interest in adults with disabilities; and
 - 6. The Director of the Bureau of Rehabilitation Services, or their designee, and
 - 7. Staff from the Long Term Care Ombudsman.
- (e) Providing training and technical assistance.
- (f) Providing written notification to the administering agencies regarding strengths, problems, violations, deficiencies or disallowed costs in the program and requiring action plans for corrections.
- (g) Assuring the continuation of services if the Bureau of Rehabilitation Services determines that an Authorized Agent's contract must be terminated.
- (h) Administering the program directly in the absence of a suitable Authorized Agent.
- (i) Conducting a request for proposals for authorized agents at least every three years thereafter.
- (j) At least annually, review the randomly selected requests for waivers of consumer payment.
- (k) Recouping CDHBC funds from administering agencies when the Bureau of Rehabilitation Services determines that funds have been used in a manner inconsistent with these rules or the Authorized Agent's contract. Review of reimbursement rates. The Director shall review the rates of reimbursement under the program subject to the provisions of 26 M.R.S.A. §1412-G.
- (l) Establish a Consumer Advisory Committee. The Bureau shall establish a Consumer Advisory Committee that shall advise the Bureau on issues concerning the administration of its consumer directed services. The Committee shall:
 - (1) be appointed by the Director of the Bureau;
 - (2) represent consumers from all parts of the State;
 - (3) consist of no more than twelve (12) members;

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- (4) be appointed for a term of no more than 2 years (with the exception of initial appointments), and each member of the Committee may serve for no more than two consecutive full terms;
- (5) initially be appointed for varied numbers of years to ensure that terms expire on a staggered basis; and
- (6) not be an employee of the Bureau, Authorized Agent, or Quality Assurance Review Committee.

(C) Authorized Agent Responsibilities

- (1) As an Authorized Agent of the Bureau the Authorized Agency shall:
 - (a) Employ staff qualified by training and/or experience to perform assigned tasks and meet the applicable licensure requirements.
 - (b) Comply with requirements of 22 M.R.S.A. §3471 et seq. and 22 M.R.S.A. §4011-4017 to report any suspicion of abuse or neglect.
 - (c) Pursue other sources of reimbursement for services prior to the authorization of HBC services.
 - (d) Operate and manage the program in accordance with all requirements established by rule or contract.
 - (e) Have sufficient financial resources, other than Federal or State funds, available to cover any HBC expenditures that are disallowed as part of the Bureau of Rehabilitation Services utilization review process.
 - (f) Inform in writing any consumer with an unresolved complaint regarding their services about how to contact the Long Term Care Ombudsman and the Bureau.
 - (g) Assure that costs to CDHBC funds for services provided to a consumer in a twelve month period do not exceed the applicable annual service plan cost limit, for which the consumer is determined eligible, established by the Bureau of Rehabilitation Services.
 - (h) Implement an internal system to assure the quality and appropriateness of assessments to determine eligibility and authorize service plans including, but not limited to the following:
 - 1. Consumer satisfaction surveys;
 - 2. Documentation of all complaints, by any party including any resolution action taken;
 - 3. Measures taken by the Authorized Agent to improve services as identified in A and B.
 - (i) Participate in the Quality Assurance Review Committee as required by the Bureau of Rehabilitation Services.
 - (j) Assure that consumers receive training on the following:
 - (i) maintaining records which comply with Maine State employment laws;
 - (ii) child labor laws and the appropriate forms to use if employing a PCA who is under eighteen (18) years of age;

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- (iii) conducting a background check on possible PCAs;
 - (iv) Hipaa confidentiality requirements; and
 - (v) information on advertising, hiring, job descriptions, supervision, management, and scheduling assistants.
 - Travel time to and from the location of the consumer is excluded.
 - (k) Assure contact with each consumer at least twice in the first six months and at least annually, or more often as deemed appropriate by staff, to verify receipt of authorized services, discuss consumer's status, review any unmet needs and provide appropriate follow-up and referral to community resources.
 - (l) Assure each Consumer's compliance with worker's compensation coverage, unemployment insurance coverage and FICA withholding for employees reimbursed with program funds.
 - (m) Make efforts to make any existing worker's compensation pools available to program consumers.
- (2) Consumer Records and Program Reports.
 - (a) Content of Consumer Records. The Authorized Agent must establish and maintain a record for each consumer that includes at least:
 - (i) The consumer's name, address, mailing address if different, telephone number, and if available, an email address;
 - (ii) The name, address, and telephone number of someone to contact in an emergency;
 - (iii) Complete medical eligibility determination form and financial assessments and reassessments that include the date they were done and the signature of the person who did them;
 - (iv) A service plan summary that promotes the consumer's independence, matches needs identified by the scores on the MED form, and is authorized by the Authorized Agent in the service plan summary on the MED form, with consideration of other formal and informal services provided and which is reviewed annually. The service plan includes:
 - (a) Evidence of the consumer's participation;
 - (b) Identification of needs;
 - (c) The desired outcome;
 - (d) Who will provide what service, when and how often, reimbursed by what funding source, the reason for the service and when it will begin and end;
 - (e) The signature of the assessor who determined eligibility and authorized a plan of service; and
 - (v) A dated release of information signed by the consumer that conforms with applicable law, is renewed annually and that:
 - (a) Is in language the consumer can understand;
 - (b) Names the agency or person authorized to disclose information;
 - (c) Describes the information that may be disclosed;

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- (d) Names the person or agency to whom information may be disclosed;
 - (e) Describes the purpose for which information may be disclosed; and
 - (f) Shows the date the release will expire.
 - (vi) Documentation that consumers eligible to apply for a waiver for consumer payments, were notified that a waiver may be available;
 - (vii) Evidence that the consumer has certified competency of the PCA
 - (viii) Written progress notes that summarize any contacts made with or about the consumer and:
 - (a) The date and duration of the contact;
 - (b) The name and affiliation of the person(s) contacted or discussed;
 - (c) Any changes needed and the reasons for the changes in the plan of service;
 - (d) The results of any findings of MDT contacts or meetings and, if applicable, of quality assurance review committee (QARC) meetings; and
 - (e) The signature and title of the person making the note and the date the entry was made;
 - (ix) Proof of required FICA, Unemployment and Workers Compensation contribution and coverage; and
 - (xi) Documentation of all complaints, by any party, including resolution action taken.
- (b) Program Reports. The following reports must be submitted to the Bureau of Rehabilitation Services, in a format approved by the Bureau of Rehabilitation Services, by the day noted:
- (1) Monthly service and consumer reports including admissions, discharges and active consumer lists, due no later than twenty days after the end of the month;
 - (2) Monthly fiscal reports, due no later than twenty days after the end of the month;
 - (3) Quarterly and annual demographic reports, due no later than twenty five days after the end of the quarter; and
 - (4) Monthly authorizations for HBC services, due by the tenth of the month for which authorizations are reported.
 - (5) Monthly reports of the type and number of assessments completed by the authorized agent as required by the contract with the Bureau of Rehabilitation Services.

8.09 CONSUMER PAYMENTS

- (A) **Consumer Payments.** The administering agency will use a Bureau of Rehabilitation Services approved form to determine income and liquid assets and calculate the monthly payment to be made by the consumer. The agency may require the consumer and his or her spouse to produce documentation of income and liquid assets. A consumer need not complete a financial assessment if he or she pays the full cost of services received. His or her payments, as determined by an annual financial assessment may not exceed the total cost of services provided.
- (B) **Definitions.** The following definitions apply to this Section.
- (1) **Dependent Allowances.** Dependents and dependent allowances are defined and determined in agreement with the method used in the MaineCare program. The allowances are changed periodically and cited in the Maine Medical Eligibility Manual, Chart II, AFDC Related Income Limits. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the consumer or consumer's spouse. A spouse may not be included.
- (2) **Disability-related expenses:** Disability-related expenses are out-of-pocket costs incurred by the consumers for their disability, which are not reimbursed by any third-party sources. They include:
- (a) Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening, environmental controls;
 - (b) Communication devices: adaptations to computers, speaker telephone, TTY, Personal Emergency Response Systems;
 - (c) Wheelchair (manual or power) accessories: lab tray, seats and back supports;
 - (d) Vehicle adaptations: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving;
 - (e) Hearing Aids, glasses, adapted visual aids;
 - (f) Assistive animals (purchase only);
 - (g) Physician ordered medical services and supplies;
 - (h) Physician-ordered prescription and over the counter drugs; ~~and~~
 - (i) Medical insurance premiums, co-pays and deductibles; and
 - (j) Unemployment and workers compensation expenses related to employing the PCA.
- (3) **Household members:** means the consumer and the spouse.

(4) Household members income includes:

- (a)** Wages from work, excluding state and Federal taxes and employer mandated or court ordered withholdings of the consumer and the spouse;
- (b)** Benefits from Social Security, Supplemental Security Income, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;
- (c)** Adjusted gross income from property and/or business, based on the consumer's most recent Federal income tax;
- (d)** Interest and dividends.
- (e)** Regularly occurring payments received from a home equity conversion mortgage.

Not included are benefits from: the Home Energy Assistance Program, Food Stamps, General Assistance, Property Tax and Rent Refund, emergency assistance programs, or their successors.

(5) A liquid asset is something of value available to the consumer that can be converted to cash in three months or less and includes:

- (a)** Bank accounts;
- (b)** Certificates of deposit
- (c)** Money market and mutual funds;
- (d)** Life insurance policies;
- (e)** Stocks and bonds;
- (f)** Lump sum payments and inheritances; and
- (g)** Funds from a home equity conversion mortgage that are in the consumer's possession whether they are cash or have been converted to another form.

Funds which are available to the consumer but which carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide income as a replacement for earned income. The income from these payments will be counted as income.

(C) Consumer Payment Formula. The Authorized Agent will use the following formula to determine the amount of each consumer's payment.

Step (1) Calculate the Monthly Contribution from the Household Income

- (a)** Total the monthly income of household members.
- (b)** Deduct monthly allowable disability related expenses.

- (c) Deduct monthly allowable dependent allowances.
- (d) Multiply the net income by 4%.

Step (2) - Calculate the Monthly Contribution from Liquid Assets.

- (a) Total the liquid assets of household members.
- (b) Deduct annual interest and annual dividends counted toward income for the household.
- (c) Subtract \$30,000 from the amount of liquid assets calculated in Step (2)(a&b).
- (d) Multiply the sum calculated in Step (2)(c) by 3%. The result is the Monthly Contribution from Liquid Assets. If the result is less than zero use zero.

Step (3) - Add the result of the calculation in Step (1)(d), to the result of the calculation in Step (2)(d).

Step (4) - The consumer's monthly payment is the lesser of the sum calculated in Step (3) or the actual cost of services provided during the month.

Step (5) - When two persons in a household are both receiving home based care services under this program, collect the required information for each person. Calculate the co-pay for each consumer and combine the total. Divide the amount by two to determine the household monthly co-payment.

(D) Waiver of Consumer Payment. Consumers will be informed that they may apply for a waiver of all or part of the assessed payment when:

- (1) Monthly income of household members is no more than 200% of the federal poverty level; and
- (2) Assets are less than \$30,000 for the household.

8.10 METHOD FOR REVIEWING REQUESTS FOR WAIVERS OF CONSUMER PAYMENT

- (A) Consumers requesting waivers may be asked to provide verification of any income, liquid assets and expenses for housing, transportation, unreimbursed medical expenses, food, clothing, laundry and insurance.
- (B) Consumers may request a waiver from the administrating agency of all or part of the assessed payment.
 - (1) The request must be submitted in writing:
 - (a) within ten (10) days of the date of notification of the assessed consumer payment, or
 - (b) within ten (10) days of the date of their last functional reassessment.
 - (2) Requests for waiver must be on a form approved by the Bureau of Rehabilitation Services.

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- (3) The administering agency will act on the request and inform the consumer of its decision in writing within twenty (20) days of receipt of the request.
- (4) If the administering agency needs additional information, in order to determine whether the waiver can be granted, the administering agency will promptly notify the consumer. The consumer must submit the additional information within ten (10) days. In such cases the agency will issue its decision within ten (10) days of receipt of the additional information.
- (C) A consumer who is otherwise eligible may receive services while awaiting the agency's decision on the request for waiver. The agency will hold the consumer payment in abeyance pending a decision on the request, or the completion of the appeals process, whichever is later.
- (D) The agency will inform the consumer in writing if the request for a waiver is approved or denied. If denied, the agency's notice must include information on appeal rights.
- (E) If the waiver is denied, the consumer payment, including payments held in abeyance, is due within thirty (30) days of the date of the decision, or services will be terminated.
- (F) When allowable expenses plus the consumer payment exceed the sum of monthly income plus the Monthly Contribution From Liquid Assets, the agency will waive the portion of the payment that causes expenses to exceed income.
- (G) Consumers who have applied for a full or partial waiver of the assessed payment and been denied may reapply only if one of the following conditions exists and is expected to continue until the next regularly scheduled financial assessment:
 - (1) the consumer has at least a 20% decrease in monthly income or liquid assets.
 - (2) has an increase in expenses which results in the sum of the allowable expenses plus the consumer payment exceeding monthly income plus the Monthly Contribution From Liquid Assets.
- (H) **Expenses.** Expenses will be reduced by the value of any benefit received from any source that pays some or all of the expense. Examples include but are not limited to, Medicare, MaineCare, Food Stamps, Elderly Low Cost Drug and Property Tax and Rent Refund. Business expenses that exceed business income are not allowable. Allowable expenses include actual monthly costs of all household members for:
 - (1) housing expenses which include and are limited to rent, mortgage payments, property taxes, home insurance, heating, water and sewer, snow and trash removal, lawn mowing, utilities and necessary repairs;
 - (2) food, clothing and laundry not to exceed;

Number in Household	1	2	3	4	5 & up
Amount	\$208	\$325	\$435	\$544	\$654

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- (3) transportation expenses which include and are limited to ferry or boat fees, car payments, car insurance, gas, repairs, bus, car and taxi fare;
- (4) unreimbursed medical expenses including but not necessarily limited to health insurance; prescription or physician ordered drugs equipment and supplies; and doctor, dentist and hospital bills;
- (5) life insurance;
- (6) child care expenses;
- (7) limited discretionary expenses.

The following chart shows maximum allowable discretionary expenses by household size. Amounts in excess of the monthly allowance may not be claimed.

Number in Household	1	2	3	4	5 & up
Amount	\$55	\$79	\$103	\$133	\$157

8.13 APPEALS PROCESS

- (A) The Bureau or its Authorized Agent must notify the consumer in writing that he/she has the right to appeal any decision to reduce, deny, suspend, or terminate services provided under this Chapter. In order for services to continue during the appeal process, the Bureau must receive a request for an appeal within ten (10) days of the notice to reduce, deny, suspend, or terminate services. Otherwise, a consumer has sixty (60) days in which to appeal a decision. The Bureau or Authorized Agent shall inform consumers in writing of their right to request an administrative hearing in accordance with this section.
- (B) Requests for appeal must be made by the consumer or his or representative in writing to the Bureau of Rehabilitation Services, CDPAS Program, 2 Anthony Avenue, Augusta ME 04333-0150, or by telephone by calling 624-5922 or 1-800-698-4440 or TTY 1-888-755-0023. The date a written or verbal request is received by the Bureau is considered the date of request for the hearing.
- (C) The hearing will be held in conformity with the Maine Administrative Procedure Act at 5 M.R.S.A. §§ 9001-9064.
- (D) The Bureau or its Authorized Agent and the consumer may be represented by others, including legal counsel.
- (E) The hearing officer on his or her own motion or at the request of either the Bureau representative or the consumer may request or subpoena persons to appear where that person can be expected to present testimony or documents relating to the issues at the hearing.

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- (F) The hearing officer shall issue a decision, which becomes final agency action, unless either the Bureau representative or the consumer requests in writing that the Commissioner, or the Commissioner's designee, of the Department of Labor reconsider the hearing officer's decision. The Department must receive such written request within ten days of the issuance of the hearing officer's decision. The Commissioner, or the Commissioner's designee, shall issue a decision based on the existing record and written argument by the parties if requested. The Commissioner's, or the Commissioner's designee, decision shall constitute final agency action.

- (G) Any party who is dissatisfied with the final agency action has the right to judicial review under 5 M.R.S.A. §§ 11001-11008 and the Maine Rules of Civil Procedure, Rule 80C.