

SECTION 1915(c) WAIVER FORMAT

- 1. The State of Ohio requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

- a. _____ Yes
- b. **x** No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

- a. _____ 3 years (initial waiver)
- b. **x** 5 years (renewal waiver)

- 2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

- a. _____ Nursing facility (NF)
- b. **x** Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)
- c. _____ Hospital
- d. _____ NF (served in hospital)
- e. _____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. _____ aged (age 65 and older)

b. _____ disabled

c. _____ aged and disabled

d. **x** mentally retarded

e. **x** developmentally disabled

f. _____ mentally retarded and developmentally disabled

g. _____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. _____ Waiver services are limited to the following age groups (specify):

b. _____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

- The individual will be given the opportunity to apply for an alternative home and community based waiver for which the individual is eligible that may more adequately respond to the individual's needs, to the extent that such waiver openings exist; and
- The individual will be informed and given an opportunity to request a fair hearing consistent with the requirements under 42 CFR 431.210, .211, .221; and 430 subpart D.

At the time that the renewal is anticipated to occur, ODMR/DD plans to begin implementation of a fee schedule as the waiver reimbursement methodology. This methodology will be phased in over the course of four years in accordance with proposed OAC 5123:2-9-06. During the transition period, if the waiver costs of an IO enrollee are projected to exceed the ICF/MR average cost, ODMR/DD will not propose to disenroll the waiver enrollee. If this situation does occur, the ISP team will work with the enrollee to ensure their health and welfare through adding more natural supports or accessing available non-waiver supports. Non-waiver supports include other Medicaid services, and state or locally funded services.

If, at the end of the proposed OAC 5123:2-9-06 transition period, the enrollee's waiver costs are projected to exceed the waiver cap and ISP team efforts are unsuccessful in ensuring the health and welfare of the enrollee, even with the addition of more natural supports or accessing available non-waiver supports:

- The individual will be given the opportunity to apply for an alternative home and community based waiver for which the individual is eligible that may more adequately respond to the individual's needs, to the extent that such waiver openings exist; and
- The individual will be informed and given an opportunity to request a fair hearing consistent with the requirements under 42 CFR 431.210, .211, .221; and 430 subpart D.

In this situation, waiver services will be continued during the pendency of a timely requested hearing even

if continuing the services will result in the enrollee's waiver costs exceeding the waiver cap.

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

- a. _____ Yes
- b. **X** No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

- a. _____ Case management
- b. _____ Homemaker
- c. _____ Home health aide services
- d. _____ Personal care services
- e. **X** Respite care
- f. _____ Adult day health
- g. **X** Habilitation
- _____ Residential habilitation

- Day habilitation
- Prevocational services
- Supported employment services
- Educational services

- h. Environmental accessibility adaptations
- i. Skilled nursing
- j. Transportation
- k. Specialized Medical Equipment and Supplies
- l. Chore services
- m. Personal Emergency Response Systems
- n. Companion services
- o. Private duty nursing
- p. Family training
- q. Attendant care
- r. Adult Residential Care
- Adult foster care
- Assisted living

- s. Extended State plan services (Check all that apply):
 - Physician services
 - Home health care services
 - Physical therapy services

- _____ Occupational therapy services
- _____ Speech, hearing and language services
- _____ Prescribed drugs
- _____ Other (specify):

t. **x** Other services (specify): **Homemaker/personal care (H/PC), Social Work/Counseling, Interpreter, Nutrition, Home-Delivered meals.**

u. _____ The following services will be provided to individuals with chronic mental illness:

- _____ Day treatment/Partial hospitalization
- _____ Psychosocial rehabilitation
- _____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written

plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a. When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
 - b. Meals furnished as part of a program of adult day health services.
 - c. When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under

this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
- c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair

hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports

of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. Yes b. No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

18. An effective date of January 1, 2004 is requested.

19. The State contact person for this request is Kim Austin or Jan Sennett, who can be reached by telephone at (614) 466-6742.

20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:

Print Name: **Barbara Coulter Edwards**

Title: **State Medicaid Director**

Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to

Individual Options Waiver

VERSION 06-95

the Office of Information and Regulatory Affairs, Office of
Management and Budget, Washington, D.C. 20503.

STATE: Ohio

13

DATE: January 1, 2004

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

 The waiver will be operated by the **Ohio Department of MR/DD**, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

_____ The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

ATTACHMENT A-1 QUALITY ASSURANCE SYSTEM

Ohio has a comprehensive, systematic approach for assuring the health and welfare of individuals receiving home and community-based services. The following describes the components of the quality assurance and compliance process.

As the single state Medicaid agency, the Ohio Department of Job and Family Services (ODJFS) provides subrecipient oversight and compliance monitoring of all waiver program and administrative activity.

- In addition to other waiver monitoring activity, ODJFS conducts targeted reviews of a representative sample of waiver recipients, including IO.
- ODJFS conducts look-behind compliance reviews of ODMR/DD

The Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD) both directly performs essential functions related to protecting and promoting the health and welfare of individuals and provides subrecipient oversight and compliance monitoring of waiver activities.

Functions directly performed by ODMR/DD to assure health and welfare include:

- Certification of waiver providers;
- Operating an internet-based Incident Tracking System (ITS);
- Administering a statewide mrdd abuse registry;
- Conducting monthly mortality reviews;
- Performing accreditation reviews of County Boards of MR/DD;
- Conducting quality assurance reviews; and
- Providing technical assistance to County Boards, providers, individuals and their families.

Functions directly performed by ODMR/DD related to subrecipient oversight and compliance monitoring of health and welfare issues include:

- Assuring that County Boards afford enrollees a free choice of approved providers;

- Assuring that County Boards conduct appropriate application intake procedures and appropriately issue level of care recommendations; and
- Reviewing Major Unusual Incident (MUI) data, both on an individual and an aggregate basis, to protect individuals from harm, to determine patterns and trends of activities, to promote systems changes that would reduce MUIs and work with County Boards to investigate incidents.

The County Boards of Mental Retardation and Developmental Disabilities (CBMR/DD), in their role as Medicaid Local Administrative Authority (MLAA) provide ongoing quality assurance activities through the following activities:

- Implementing an ongoing system of quality assurance oversight with continuous quality improvement activities through individual service plan implementation;
- Coordinating the services and monitoring the delivery of those services as specified in the ISP by a Service and Support Administrator;
- Identifying patterns and trends of unusual and major unusual incidents; and
- Performing quality assurance reviews of waiver recipients, using the findings to modify and improve the quality of individual plans, and identifying outcomes achieved and the individual's satisfaction with services delivered.

Emergency Removal

Current law provides for the emergency removal of individuals from licensed residential facilities where residents are in imminent danger of serious physical or psychological harm.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. _____ Case Management

_____ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. _____ Yes 2. _____ No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. _____ Yes 2. _____ No

_____ Other Service Definition (Specify):

b. _____ Homemaker:

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

_____ Other Service Definition (Specify):

c. _____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

_____ Other Service Definition (Specify):

d. _____ Personal care services:

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living.

This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members
(Check one):

_____ Payment will not be made for personal care services furnished by a member of the individual's family.

_____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached.
(Check one):

_____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

_____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

_____ A registered nurse, licensed to practice nursing in the State.

_____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

_____ Case managers

_____ Other (Specify):

3. Frequency or intensity of supervision (Check one):

_____ As indicated in the plan of care

_____ Other (Specify):

4. Relationship to State plan services
(Check one):

_____ Personal care services are not provided under the approved State plan.

_____ Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

_____ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_____ Other service definition (Specify):

e. **x** Respite care:

 x Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

_____ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care will be provided in the following location(s) (Check all that apply):

- Individual's home or place of residence
- _____ Foster home
- _____ Medicaid certified Hospital
- _____ Medicaid certified NF
- Medicaid certified ICF/MR
- _____ Group home
- _____ Licensed respite care facility
- Other community care residential facility approved by the State that its not a private residence
(Specify type): **Facility licensed by ODMR/DD in accordance with Ohio Revised Code 5123.19 or home of a certified supported living provider.**

_____ Other service definition (Specify):

f. _____ Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. _____ Yes 2. _____ No

_____ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. **X** Habilitation:

_____ Services designed to assist individuals in acquiring, retaining and improving the self-

help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

_____ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

_____ Day habilitation: assistance with acquisition, retention, or

improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a

25

STATE: Ohio

DATE: January 1, 2004

transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

_____ Individuals will not be compensated for prevocational services.

_____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a

SNF, ICF, NF, or ICF/MR at some prior period.

_____ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

_____ **x** Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services,

including supervision and training.

When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

a. _____ Yes b. X No

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an

employer to encourage or subsidize the employer's participation in a supported employment program;

- 2. Payments that are passed through to users of supported employment programs; or
- 3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. _____ Yes 2. X No

_____ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. **x** Environmental accessibility adaptations:

 x Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

 Other service definition (Specify):

i. Skilled nursing:

 Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a

registered nurse, licensed to practice in the State.

_____ Other service definition (Specify):

j. **x** Transportation:

_____ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

 x Other service definition (Specify):
Transportation is any vehicle services, other than ambulance, ambulette and other transportation services provided through the Medicaid state plan, which enables a recipient to obtain health related or developmental services, as well as transportation to and from a supported employment site. Use of generic transportation services will be explored and used prior to payment for services under the HCBS waiver.

k. x Specialized Medical Equipment and Supplies:

 x Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with he environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

 Other service definition (Specify):

l. Chore services:

 Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, nd where no other relative, caregiver, landlord, community/volunteer agency, or

third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other service definition (Specify):

m. _____ Personal Emergency Response Systems (PERS)

_____ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility.

The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2.

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_____ Other service definition (Specify):

n. _____ Adult companion services:

_____ Non-medical care, supervision and socialization, provided to a functionally

impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (Specify):

o. _____ Private duty nursing:

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

_____ Other service definition (Specify):

p. _____ Family training:

_____ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer.

Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

_____ Other service definition (Specify):

q. _____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-

provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements (Specify):

_____ Other service definition (Specify):

r. _____ Adult Residential Care (Check all that apply):

_____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed_____).

Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care

services, since these services are integral to and inherent in the provision of adult foster care services.

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility.

This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living

rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- _____ Home health care
- _____ Physical therapy
- _____ Occupational therapy
- _____ Speech therapy
- _____ Medication administration
- _____ Intermittent skilled nursing services
- _____ Transportation specified in the plan of care
- _____ Periodic nursing evaluations
- _____ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not

available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

_____ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

- s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify): **Homemaker/personal care (HPC), Social Work, Nutrition, Interpreter, Home-Delivered Meals. (See Attachment B-1).**

d. Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____ Physician services

- _____ Home health care services
- _____ Physical therapy services
- _____ Occupational therapy services
- _____ Speech, hearing and language services
- _____ Prescribed drugs
- _____ Other State plan services (Specify):

e. Services for individuals with chronic mental illness, consisting of (Check one):

_____ Day treatment or other partial hospitalization services (Check one):

_____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

f. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

g. occupational therapy, requiring the skills of a qualified occupational therapist,

h. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

i. drugs and biologicals furnished for therapeutic purposes,

j. individual activity therapies that are not primarily recreational or diversionary,

- k. family counseling (the primary purpose of which is treatment of the individual's condition),
- l. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- m. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify):

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- n. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- o. social skills training in appropriate use of community services;

- p. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- q. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- r. vocational services,
- s. prevocational services,
- t. supported employment services, and
- u. room and board.

_____ Other service definition (Specify):

_____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

_____ This service is furnished only on the premises of a clinic.

_____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

ATTACHMENT B-1: DEFINITION OF SERVICES**1. HOMEMAKER/PERSONAL CARE (H/PC)**

Homemaker/Personal Care (HPC) means tasks directed at the consumer or the consumer's immediate environment that are necessitated by his or her physical or mental condition (includes emotional and/or behavioral). The level of care is of a supportive or maintenance type, and the tasks encompassed requires less skill than some of the duties included in home health care performed by home health aides. This service will help the consumer meet daily living needs, and without this service alone or in combination with other waiver services the individual would require institutionalization.

The homemaker/personal care provider should perform such tasks as assisting the consumer with activities of daily living, personal hygiene, dressing, feeding, transfer, and ambulatory needs or skills development. Skill development is intervention, specifically tailored in its type and frequency to maximize the consumer's capabilities, that focuses on both preventing the loss of skills and enhancing skills that are already present that will lead to greater independence within the residence or the community. The provider may also perform homemaking tasks for the consumer. These tasks may include cooking, cleaning, laundry and shopping, among others. Homemaking and personal tasks are combined into a single service titled homemaker/personal care because, in actual practice, a single individual provides both services and does so as part of the natural flow of the day. For example, the provider may prepare a dish and place it in the oven to cook (homemaking), assist the consumer in washing up before a meal and assist him/her to the table (personal care), put the prepared meal on the table (homemaking) and assist the consumer in eating (personal care). Segregating these activities into discrete services strains the bounds of credibility.

Services provided include the following:

- Basic personal care and grooming, including bathing, care of the hair and assistance with clothing.
- Assistance with bladder and/or bowel requirements or problems, including helping the consumer to and from the

bathroom or assisting the consumer with bedpan routines.

- Assisting the consumer with medications, which are ordinarily self-administered when ordered by the consumer's physician.
- Performing household services essential to the consumer's health and comfort in the home (e.g. necessary changing of bed linens or rearranging of furniture to enable the consumer to move about more easily in his/her home).
- Assessing, monitoring and supervising the consumer to ensure the consumer's safety, health and welfare.
- Light cleaning tasks in areas of the home used by the consumer.
- Preparation of a shopping list appropriate to the consumer's dietary needs and financial circumstances, performance of grocery shopping activities as necessary and preparation of meals.
- Personal laundry.
- Incidental neighborhood errands as necessary, including accompanying the consumer to medical and other appropriate appointments and accompanying consumers for short walks outside the home.

Homemaker/personal care providers shall:

- Participate in the consumer's Individual Service Plan (ISP) meetings if and when they are requested by the consumer's team.
- Perform tasks and duties according to the ISPs.
- Maintain a clean and safe environment.
- Be sensitive to the consumer's and family's needs.
- Recognize changes in the consumer's condition and behavior as well as safety and sanitation hazards, report the to the case manager and record them in the consumer's written record.
- Document all services provided to and on behalf of the consumer.

2. SOCIAL WORK/COUNSELING

Social Work/Counseling means the application of specialized knowledge of human development and behavior, social economic and cultural systems. This knowledge is used to directly assist consumers and their families to improve or restore their capacity for social functioning. The clinical nature of the task will include the use of counseling techniques, appraisal skills, consulting abilities and a variety of treatment modalities and interventions to help the consumer and/or caregiver.

Social Workers/Counselors may:

- Document social needs and develop a social work/counseling plan of treatment;
- Provide direct service in the form of counseling and actively participate in resolving problems;
- Counsel consumers and involved family members with regard to the consumer's psychosocial needs;
- Collaborate with the physician and assist various providers of service in understanding emotional problems and social needs of the person with physical disabilities;
- Recognize the social problems of the consumer and caregiver and take appropriate therapeutic intervention;
- Refer consumers/family to case management for financial matters or interagency collaboration and follow-up;
- Assist consumer, staff and family to resolve problems which prevent the consumer's social adjustment or any other problems which affect the consumer's ability to benefit from medical treatment;
- Assist the consumer to develop self help skills, socialization and adaptive skills that can enable the consumer to remain functional outside an institution;
- Act as an advocate for the consumer's social needs;
- Arrange consumer and caregiver counseling and other supportive services in alleviating some of the pressures of estrangement from social support systems such as family, employment and residential placements; and,
- Participate in the development and review of the consumer's ISP when requested.

This service alone or in conjunction with other services prevents institutionalization of the consumer.

3. NUTRITION

Nutrition services means a nutritional assessment and intervention for consumers who are identified as being at nutritional risk. The service includes development of a nutrition care plan, including appropriate means of nutritional intervention, i.e. nutrition required, feeding modality, nutrition education and nutrition counseling.

The Dietitian shall:

- Participate in the development of the consumer's annual individual service plan (ISP) if requested;
- Perform nutritional assessments/evaluations in accordance with the ISP;
- Develop dietary programs, if indicated by the nutritional assessment and the ISP;
- Document all hands-on programming performed;
- Inservice and/or train the consumer/family/guardian, professionals, paraprofessionals, direct care workers, habilitation specialists, vocational/school staff (including public personnel) as needed.

Nutrition services will not supplant existing services provided by the Women Infants and Children (WIC) program.

This service alone or in conjunction with other services prevents institutionalization of the consumer.

4. INTERPRETER

Interpreter services means the process by which an individual conveys one person's message to another. The process of interpreting should incorporate both the message and the attitude of the communicator. The interpreter will maintain the role of a facilitator of communication rather than the focus or initiator of communication.

Providers of interpreter services shall:

- Render the message faithfully, always conveying the content and the spirit of the consumer, using language most readily understood by the persons whom they serve;
- Not counsel, advise or interject personal opinions;
- Participate in the consumer's ISP team if and when requested by the consumer's team.

Interpreter services are entities of the consumer's Individual Service Plan (ISP).

This service alone or in conjunction with other services prevents institutionalization of the consumer.

5. HOME DELIVERED MEALS

Home delivered meals means the preparation, packaging and delivery of one or more meals to consumers who are unable to prepare or obtain nourishing meals. A full regimen of three meals a day shall not be provided under the HCBS waiver.

This service alone or in conjunction with other services prevents institutionalization of the consumer.

Providers of home delivered meals shall:

- Initiate new orders for home delivered meals within seventy-two (72) hours of referral if specified by the service plan;
- Participate in the consumer's Individual Service Plan (ISP) meetings if and when requested by the consumer's team;
- Be able to provide two (2) meals per day, seven days per week;
- Assure that home delivered meals are delivered to each consumer in accordance with the consumer's ISP;
- Possess the capability to provide special diets including, but not limited to, sodium and low sugar;
- Ensure that each meal served contains at least one-third of the current recommended dietary allowance as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council;

- **Have a licensed dietitian approve and sign all menus; and,**
- **Shall have a licensed dietitian plan and write all special menus in accordance with the ISP.**

STATE: Ohio

DATE: January 1, 2004

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Service	Provider	License	Certification	Other Standard
Respite	ICF/MR facility		Certified as an ICF/MR according to ORC 3721.22	See Attachment B-2
	Licensed facility		Licensed according to ORC 5123.19	
	Independent or Agency Provider		Certified as a waiver provider per ORC 5123.45	
Supported Employment	Independent Provider		Certified as a waiver provider per ORC 5123.45	See Attachment B-2
Environmental Accessibility Adaptations	Independent Provider		Certified as a waiver provider per ORC 5123.45	See Attachment B-2
Specialized Medical Equipment And Supplies	Independent Provider		Certified as a waiver provider per ORC 5123.45	See Attachment B-2
Transportation	Independent or Agency Provider		Certified as a waiver provider per ORC 5123.45	See Attachment B-2

Homemaker/ Personal Care	Independent or Agency Provider		Certified as a waiver provider per ORC 5123.45	See Attachment B-2
Social Work/ Counseling	Independent or Agency Provider	ORC 4757		See Attachment B-2
Interpreter	Independent or Agency Provider		Certified as an Interpreter by RID	See Attachment B-2
Nutrition	Independent Provider	ORC 4759		See Attachment B-2
Home Delivered Meals	Independent Provider		Title III-C	See Attachment B-2

ATTACHMENT B-2: CERTIFICATION AND OTHER STANDARDS**1. RESPITE CARE**

Respite care may be provided out-of-home in intermediate care facilities for the mentally retarded (ICFs/MR) or facilities licensed by ODMR/DD under section 5123.19 of the Revised Code or in the home of a supported living or an approved individual options homemaker/personal care provider.

2. HABILITATION: SUPPORTED EMPLOYMENT

Supported Employment services are provided by an agency or individual providers certified pursuant to ORC 5123.045.

All providers are certified pursuant to ORC 5123.045. Staff employed by these agencies who provide supported employment waiver services shall demonstrate at least one year of experience providing supporting employment services or related services or show evidence of at least one formal training in community/supported employment. Agency providers of Waiver Supported Employment shall meet all applicable health and safety requirements of OAC Chapter 5123.

Individuals not employed by agencies who are certified to provide Supported Employment services shall demonstrate at least one year of experience providing supporting employment services or related services or show evidence of at least one formal training in community/supported employment. Individuals who provide Waiver Supported Employment shall meet all applicable health and safety requirements of OAC Chapter 5123.

Providers of supported employment must assure that there is adequate substitute coverage in the event that the provider is not able to provide coverage as specified in the individual's ISP. The provider shall notify the individual when the provider is obtaining another certified provider who can provide substitute coverage.

Providers shall not agree to provide services to any enrollee whose needs the provider cannot meet. Providers shall provide written assurances that the provider and all staff of the provider who provide supported employment services have sufficient background and training to protect the health and welfare of the enrollee in the execution of the duties assigned to the provider in the ISP and PAWS authorization for services.

ODJFS and ODMR/DD will sanction for failure to provide authorized services. Sanctions include technical assistance, mandatory training, plans of correction, temporary suspension on providing services to additional waiver enrollees, penalties, fines, termination of provider agreement and recoupment of waiver payment for any time claimed and reimbursed as Supported Employment when requirements were not met. Specific sanctions, the compliance monitoring process, and

roles of State agencies and their subrecipients, including County Boards of MR/DD and the provider appeal process will be specified in Ohio Administrative Code.

3. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Environmental accessibility adaptations may be provided by construction companies or individuals. Estimates will be sought and the lowest and best estimate will be selected. Any applicable license or certification requirements will be met.

4. TRANSPORTATION

Transportation services may be provided by any agency or individual. Each provider of private automobile services must show proof of a valid Ohio driver's license as well as full liability insurance coverage. Any public provider of transportation services such as a bus or taxi company must comply with whatever state and/or local regulations apply to the operation of their business.

5. SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Companies and individuals who provide specialized medical equipment & supplies must:

- Meet all applicable licensure and certification requirements.
- Have a provider agreement with the single state Medicaid agency.
- Have all work meet ISP requirements as verified by the County Board of MR/DD.

Any agency or individual who is approved as either a medical equipment supplier or a provider of supplies and medical equipment under the Medicaid state plan may provide the services. Providers approved prior to the approval date of this amendment shall be deemed as meeting the provider standards for this service. Veterinarians providing services to support animals must be appropriately licensed by the State of Ohio.

6. HOMEMAKER/PERSONAL CARE

Homemaker/personal care services may be provided by any individual, other than the consumer's spouse or the parent of a minor (under age 18) who meets the homemaker/personal care standards as required by Ohio Administrative Code 5123:2-12-02.

7. SOCIAL WORK/COUNSELING

Social work/counseling services will be provided by a licensed social worker who is licensed to engage in social work as defined in Division (C) of Section 4757.01 of the Ohio Revised Code and 4757:15-02 of the Administrative Code or by a licensed counselor who is licensed in the State of Ohio to engage in professional or clinical counseling as defined in division (A) and (B) of Section 4757.01 of the Ohio Revised Code.

8. INTERPRETER

Interpreter services will be provided by an individual meeting one of the following criteria groups:

- Certified interpreter, as certified by the Registry of Interpreters for the Deaf, Inc. (RID);
- Non-certified interpreters, including:
 - Graduates of interpreter training programs (minimum two (2) year program) plus one year of documented service experience;
 - Individual with successful completion of written test plus one year of documented service experience; and
 - Individuals with two years of documented service experience.

9. NUTRITION

Nutrition services will be provided by a dietician licensed by the State of Ohio.

10. HOME DELIVERED MEALS

Home delivered meals may be supplied by an agency that meets all applicable regulatory requirements for the preparation, packaging and delivery of home delivered meals as defined by the Title III-C Program.

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C: ELIGIBILITY AND POST-ELIGIBILITY

APPENDIX C-1: ELIGIBILITY

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1. Low income families with children as described in section 1931 of the Social Security Act.
2. SSI recipients (SSI Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. Optional State supplement recipients
5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%.
6. The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

A. Yes B. No

Check one:

a. The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) A special income level equal to:

300% of the SSI Federal benefit (FBR)

% of FBR, which is lower than 300% (42 CFR 435.236)

\$ which is lower than 300%

(2) Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4) Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5) Aged and disabled who have income at:

a. 100% of the FPL

b. % which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

STATE: Ohio

DATE: January 1, 2004

ATTACHMENT C-1: ADDITIONAL TARGETING CRITERIA UNDER SECTION 1902(a)(10)(B) OF THE SOCIAL SECURITY ACT

The following additional criteria are used to limit who will receive services under the waiver:

- As an alternative to first come, first served on a statewide basis, waiver enrollment numbers shall be allocated across the state to County Boards of MR/DD, who will manage enrollment on a county-by-county basis in accordance with Ohio Administrative Code 5123:2-1-08 requirements.
- Applicants and current enrollees whose health and safety cannot be assured without HCBS waiver service cost exceeding the maximum average cost established in accordance with Ohio Administrative Code 5123:2-04 shall not be enrolled or are subject to disenrollment.
- Applicants and current enrollees who currently reside or were deinstitutionalized from a general nursing facility (NF) as a result of PASRR mandated by PL 100-203, Nursing Home Reform Act, OBRA, 1987, as amended by OBRA, 1990, 42 U.S.C. Section 1396 (e) (7) to require specialized services shall be or shall remain eligible as long as specialized services are needed or the individual must have an ICF/MR level of care as defined by 42 CFR 435.1009.
- The individual's health and safety needs, met by formal supports, informal supports and home and community based services, must be assured.

APPENDIX C-2: POST-ELIGIBILITY

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard

60

STATE: Ohio

DATE: January 1, 2004

to apply.

- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. _____ **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. ~~§ 435.726~~--States which do not use more restrictive eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.____ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):____%

(5)___ Other (specify):

B.____ The following dollar amount:

\$_____*

* If this amount changes, this item will be revised.

C. The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A.____ SSI standard

B.____ Optional State supplement standard

C.____ Medically needy income standard

D.____ The following dollar amount:
\$_____*

* If this amount changes, this item will be revised.

E.____ The following percentage of the following standard that is not greater than the standards above: _____% of standard.

F.____ The amount is determined using the following formula:

G.____ Not applicable (N/A)

3. Family (check one):

A.____ AFDC need standard

B.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.____ The following dollar amount:
\$_____*

*If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above: % of ____ standard.

E.____ The amount is determined using the following formula:

F.____ Other

G.____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b) X **209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. 42 CFR 435.735--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. ___ The following standard included under the State plan (check one):

(1) ___ SSI

(2) ___ Medically needy

(3) ___ The special income level for the institutionalized

(4) ___ The following percentage of the Federal poverty level: ___%

(5) ___ Other (specify):

B. ___ The following dollar amount: \$ ___*

* If this amount changes, this item will be revised.

C. X The following formula is used to determine the amount: **65% of 300% of the SSI payment for an individual.**

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A.____ The following standard under 42 CFR 435.121:

B.____ The medically needy income standard_____;

C.____ The following dollar amount:
\$_____*

* If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above:_____% of

E.____ The following formula is used to determine the amount:

F.____ Not applicable (N/A)

3. family (check one):

A.____ AFDC need standard

B.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.____ The following dollar amount:
\$_____*

* If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above: _____% of standard.

E.____ The following formula is used to determine the amount:

F. Other: **An amount equal to the need standard for a family of the same size used to determine eligibility under the State's approved 1931 plan.**

G.____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. X The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level:
___%

(e)___ The following dollar amount
\$ ___**

**If this amount changes, this item will be revised.

(f) X The following formula is used to determine the needs allowance: **65% of 300% of the SSI payment for an individual.**

(g)___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D: ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

_____ Discharge planning team

_____ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_____ Licensed Social Worker

 X Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
County Board certified staff performing the Service and Support Administrator (SSA) function collect assessment information, complete the Level of Care form and make a recommendation to ODMR/DD. ODMR/DD OMRPs make the final ICF/MR Level of Care determination.

_____ Other (Specify):

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

- _____ Every 3 months
- _____ Every 6 months
- Every 12 months
- _____ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

_____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

- _____ Physician (M.D. or D.O.)
- _____ Registered Nurse, licensed in the State
- _____ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_____ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

"Tickler" file

Edits in computer system

_____ Component part of case management

Other (Specify): **Integral part of required coordinating activities which are the responsibility of the County Boards of MR/DD. ODMR/DD monitors the County Boards of MR/DD's compliance.**

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

_____ By the Medicaid agency in its central office

_____ By the Medicaid agency in district/local offices

 x By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

_____ By the case managers

 x By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

_____ By service providers

_____ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix. **(See ATTACHMENT D-3)**

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed

description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

ATTACHMENT D-3: LEVEL OF CARE FORMS

ODMR/DD uses standardized forms for the

- [Initial Level of Care Eligibility Determination;](#)
- [Level of Care Redetermination/No Significant Change in Condition;](#) and
- [Level of Care Redetermination/Significant Change in Condition.](#)

These forms can be accessed by clicking on the form name.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and
 - b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
The Free Choice of Provider form can be found at:
<http://odmrdd.state.oh.us/Includes/Waivers/FreedomOfChoice.pdf> (See also Attachment D-4)
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

- d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

**Residential facility where the individual resides and
County Board of MR/DD.**

**ATTACHMENT D-4: DESCRIPTION OF FREE CHOICE OF PROVIDER,
FEASIBLE ALTERNATIVES AND OPPORTUNITY FOR FAIR HEARING**

As part of the annual re-determination process, the SSA includes notice to the enrollee that s/he can choose HCBS in lieu of ICF/MR placement.

Consistent with the requirements under 42 CFR 431.210, .211, .221; and 430 subpart D, individuals are informed and given the opportunity to request a fair hearing if the state proposes to terminate the individual's waiver eligibility. In addition, Ohio law requires that individuals be afforded a request for a hearing if either the Ohio Department of Job and Family Services or the Ohio Department of Mental Retardation and Developmental Disabilities denies an application for home and community based services.

If either department approves, reduces, denies or terminates an HCBS service, that department shall give the affected individual timely notice, including the opportunity to request a hearing under ORC section 5101.35. Waiver services are continued during the pendency of a timely requested hearing, even if continuing the services will result in the enrollee's waiver costs exceeding the waiver cap.

Ohio uses standardized forms developed by ODJFS. They include the following forms:

- Notice of Action Taken on Your State Hearing Request (JFS 4000);
- Notice of Medical Determination and a Right to a State Hearing (JFS 04022);
- Explanation of State Hearing Procedures (JFS 04059);
- Prior Notice to Right to State Hearing (JFS 04065);
- Notice of Approval of Your Application for Assistance (JFS 04074); and
- Notice of Denial of Your Application for Assistance (JFS

07334)

The above information is shared with the recipient and can be found at:

- [Notice of Action Taken on Your State Hearing Request](#) (JFS 4000);
- [Notice of Medical Determination and a Right to a State Hearing](#) (JFS 04022);
- [Explanation of State Hearing Procedures](#) (JFS 04059);
- [Prior Notice to Right to State Hearing](#) (JFS 04065);
- [Notice of Approval of Your Application for Assistance](#) (JFS 04074); and
- [Notice of Denial of Your Application for Assistance](#) (JFS 07334)

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

- 1. The following individuals are responsible for the preparation of the plans of care:

- _____ Registered nurse, licensed to practice in the State
- _____ Licensed practical or vocational nurse, acting within the scope of practice under State law
- _____ Physician (M.D. or D.O.) licensed to practice in the State
- _____ Social Worker (qualifications attached to this Appendix)
- X** Case Manager **In Ohio, this person is called the Service and Support Administrator. (See Attachment E-1)**
- _____ Other (specify):

- 2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

- _____ At the Medicaid agency central office
- _____ At the Medicaid agency county/regional offices

- By case managers **In Ohio, Case Managers are known as Service and Support Administrators (SSA). SSAs are employees or contractors of the County Board of MR/DD in their role as Medicaid Local Administrative Authorities (MLAA).**
- By the agency specified in Appendix A
- By consumers
- Other (specify): **At the County Board of MR/DD**

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

- _____ Every 3 months
_____ Every 6 months
 x Every 12 months
_____ Other (specify):

ATTACHMENT E-1: PLAN OF CARE DEVELOPMENT

Identify the individuals responsible for the preparation of the plans of care.

Service and Support Administration (SSA) services are provided through Ohio's Medicaid state plan via Targeted Case Management (TCM). The SSA's responsibilities include working with the enrollee and their team in the development individual service plan (ISP). The SSA is provided through the County Board of MR/DD in their role as Medicaid Local Administrative Authority (MLAA). The designated SSA is identified on each waiver enrollee's ISP. The SSA shall not delegate:

The explanation of feasible alternatives available under the waiver;

The explanation of freedom of choice of provider;

Approval of the individual service plan (subject to the final approval of ODJFS) or

The authorization for the payment of waiver services.

In addition, the designated SSA shall perform the following functions:

Coordinate the initial enrollment and redetermination processes, which include assessment, service planning, preparation of the written service plan, review of implementation and plan revision as indicated by the review.

Ensure that the service plan includes services, without regard to funding source, which are needed to ensure health and safety and prevent institutionalization and ensure that habilitation services are addressed that include skill development and/or intervention(s) directed at prevention of further loss of skills.

Coordinate the services and activities being provided to the individual with all service providers.

Notify the individual and service providers when services

are effective and can begin.

Communicate to designated persons when the individual is hospitalized or when other changes in the individual's status have occurred which could result in suspension of disenrollment from the waiver.

Confirm with the individual within ten days following the effective enrollment date that waiver services were initiated.

Coordinate activities related to quality assurance reviews, which involve the individual.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The Medicaid agency conducts periodic on-site audits of service plans. A random sample of recipient ISPs will be selected. The audit will include a face-to-face assessment of the recipient.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

Individual plans of care are regulated in accordance with Ohio Administrative Code 5123:2-3-17 for individuals in licensed settings and Attachment E-2 for individuals who live in their own homes or with family. A specific form is not required, however, the form used must include all data elements required in b.1 above. Ohio does require that payment authorization for waiver services (known as PAWS) be accomplished using a statewide form.

ATTACHMENT E-2: PLAN OF CARE

An Individual Service Plan (ISP), or plan of care, shall be developed for each waiver enrollee and shall:

- Be written;
- Be developed by qualified persons with input from the waiver enrollee;
- Describe, regardless of funding source, medical and other services identified through the assessment process to be furnished to the recipient, the service frequency, the service duration, the type of provider who will furnish each service, and the completion and approval date(s) of the ISP;
- Be subject to the approval of the Medicaid agency;
- Identify the County Board representative (SSA) responsible for service coordination;
- Maximize the use of natural supports and generic resources; and
- Be maintained for a minimum period of seven years from the ISP effective date or for six years after any initiated audit is completed and adjudicated; whichever is longer.

In addition, to recommend an ISP for approval, the County Board is required to do all of the following:

- Ensure that the ISP reflects the services needed for health and safety and to prevent institutionalization;
- Ensure that the ISP contains, at a minimum, the type of services to be furnished, the frequency and duration of each service, and the type of provider to furnish each service; and
- Ensure that habilitation services are addressed and include skill development and/or intervention(s) directed at the prevention of further loss of skills.

The service plan requirements for waiver enrollees in licensed facilities must be pursuant to OAC 5123:2-3-17.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

 x Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

 Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

 Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

_____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

- a. When the individual was eligible for Medicaid waiver payment on the date of service;
- b. When the service was included in the approved plan of care;
- c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

Yes

_____ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

All claims are processed through an approved MMIS.

_____ MMIS is not used to process all claims.
Attached is a description of records
maintained with an indication of where they
are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

ATTACHMENT F: BILLING PROCESS

b. BILLING PROCESS AND RECORDS RETENTION

- 1a. Process to determine individual was eligible for Medicaid waiver payment on the date of service.

MMIS will reimburse claims for waiver service only for individuals who are shown to be eligible for Medicaid payment and are determined eligible for the waiver on the date of service. This is accomplished by causing an interface to occur between MMIS and Ohio's Cris-E Eligibility Data System. MMIS only approves claims for individuals who are Medicaid and HCBS waiver eligible.

- 1b. Process to determine that the service was included in the approved individual service plan (plan of care).

Prior to adjudication by MMIS, a Provider's claim for payment of HCBS waiver services must first clear an MR/DD data system. The MR/DD data system rejects any provider claim for payment of service unless all of the following elements exist:

- The recipient was authorized to receive the service claimed for payment, and
- The date of such service was on or after the effective date of the individual's enrollment, and
- The provider was approved, on or prior to the effective date of the individual's enrollment, to provide such service for the individual.

Provider claims for waiver services will be rejected by the MR/DD data system once the total number of units approved for the individual is reached. The claim will not be forwarded and adjudication by MMIS and payment for waiver services in excess of what is authorized from the approved individual service plan will not be made.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

_____ The Medicaid agency will make payments directly to providers of waiver services.

_____ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

_____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

 X Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Ohio Department of MR/DD - The agency designated in Appendix A as responsible for administration of this waiver.

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

Claims are submitted directly to the single state agency, as do all Medicaid state plan providers.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
 COMPOSITE OVERVIEW
 COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1 (CY-04)	\$33,127	\$15,501	\$80,549	\$12,514
2 (CY 05)	\$33,955	\$15,733	\$83,973	\$12,702
3 (CY 06)	\$34,804	\$15,969	\$87,541	\$12,892
4 (CY 07)	\$35,674	\$16,209	\$91,262	\$13,086
5 (CY 08)	\$36,566	\$16,452	\$95,140	\$13,282

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR UNDUPLICATED INDIVIDUALS

1 9535

2 9535

3 9535

4 9535

5 9535

EXPLANATION OF FACTOR C:

Check one:

_____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

 x The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period. **The number listed as Factor C assumes CMS approval of the waiver amendment submitted on June 30, 2003.**

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2

METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

"D" VALUE PROJECTION
FACTOR D
LOC: ICF/MR

DEMONSTRATION OF FACTOR D ESTIMATES FOR **WAIVER YEAR #1** WHICH INCLUDES 01-JAN-04 THROUGH 31-DEC-04

Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL (B x C x D)
HOMEMAKER/PERSONAL CARE (HPC) - HOUR	4686	1198	HOUR	\$19.87	\$111,557,534
HOMEMAKER/PERSONAL CARE (HPC) - DAY	7271	192	DAY	\$121.21	\$169,222,138
SOCIAL WORK/COUNSELING	2263	39	HOUR	\$40.15	\$3,542,979
HOME-DELIVERED MEALS	10	198	1 MEAL	\$6.04	\$11,403
TRANSPORTATION	7024	1442	MILE	\$0.45	\$4,558,156
INTERPRETER	29	718	HOUR	\$16.74	\$343,813
NUTRITION	103	21	HOUR	\$52.03	\$112,517
SUPPORTED EMPLOYMENT	640	303	HOUR	\$17.93	\$3,475,891
ADAPTIVE/ASSISTIVE EQUIPMENT	960	2	ITEM	\$10,419.42	\$20,008,923
ENVIRONMENTAL MODIFICATION	477	1	ITEM	\$4,555.12	\$2,171,653
RESPIRE - DAY	183	29	DAY	\$162.30	\$861,665

<u>GRAND TOTAL (sum of Column E) :</u>	<u>\$ 315,866,672</u>
<u>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS :</u>	<u>9535</u>
<u>FACTOR D (Divide grand total by the estimated number of unduplicated recipients)</u> <u>:</u>	<u>\$ 33,127</u>

AVERAGE LENGTH OF STAY (in days) = 345

"D" VALUE PROJECTION

FACTOR D

LOC: ICF/MR

DEMONSTRATION OF FACTOR D ESTIMATES FOR **WAIVER YEAR #2** WHICH INCLUDES 01-JAN-05 THROUGH 31-DEC-05

Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL (B x C x D)
HOMEMAKER/PERSONAL CARE (HPC) - HOUR	4686	1198	HOUR	\$20.37	\$114,346,472
HOMEMAKER/PERSONAL CARE (HPC) - DAY	7271	192	DAY	\$124.24	\$173,452,692
SOCIAL WORK/COUNSELING	2263	39	HOUR	\$41.15	\$3,631,554
HOME-DELIVERED MEALS	10	198	1 MEAL	\$6.19	\$11,688
TRANSPORTATION	7024	1442	MILE	\$0.46	\$4,672,109
INTERPRETER	29	718	HOUR	\$17.16	\$352,408
NUTRITION	103	21	HOUR	\$53.33	\$115,330
SUPPORTED EMPLOYMENT	640	303	HOUR	\$18.38	\$3,562,788
ADAPTIVE/ASSISTIVE EQUIPMENT	960	2	ITEM	\$10,679.91	\$20,509,146
ENVIRONMENTAL MODIFICATION	477	1	ITEM	\$4,669.00	\$2,225,945
RESPIRE - DAY	183	29	DAY	\$166.36	\$883,207

GRAND TOTAL (sum of Column E): \$ 323,763,339
 TOTAL ESTIMATED UNDUPLICATED RECIPIENTS: 9,535
 FACTOR D (Divide grand total by the estimated number of unduplicated recipients)
 : \$ 33,955

AVERAGE LENGTH OF STAY (in days) = 345

"D" VALUE PROJECTION

FACTOR D

LOC: ICF/MR

DEMONSTRATION OF FACTOR D ESTIMATES FOR **WAIVER YEAR #3** WHICH INCLUDES 01-JAN-06 THROUGH 31-DEC-06

Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL (B x C x D)
HOMEMAKER/PERSONAL CARE (HPC) - HOUR	4686	1198	HOUR	\$20.88	\$117,205,134
HOMEMAKER/PERSONAL CARE (HPC) - DAY	7271	192	DAY	\$127.35	\$177,789,009
SOCIAL WORK/COUNSELING	2263	39	HOUR	\$42.18	\$3,722,342
HOME-DELIVERED MEALS	10	198	1 MEAL	\$6.35	\$11,980
TRANSPORTATION	7024	1442	MILE	\$0.47	\$4,788,912
INTERPRETER	29	718	HOUR	\$17.59	\$361,218
NUTRITION	103	21	HOUR	\$54.66	\$118,213
SUPPORTED EMPLOYMENT	640	303	HOUR	\$18.84	\$3,651,858
ADAPTIVE/ASSISTIVE EQUIPMENT	960	2	ITEM	\$10,946.90	\$21,021,874
ENVIRONMENTAL MODIFICATION	477	1	ITEM	\$4,785.72	\$2,281,593
RESPIRE - DAY	183	29	DAY	\$170.52	\$905,287

GRAND TOTAL (sum of Column E): \$ 331,857,420

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS: 9,535

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS : 9,535
 FACTOR D (Divide grand total by the estimated number of unduplicated recipients) : \$ 35,674

AVERAGE LENGTH OF STAY (in days) = 345

"D" VALUE PROJECTION

FACTOR D

LOC: ICF/MR

DEMONSTRATION OF FACTOR D ESTIMATES FOR **WAIVER YEAR #5** WHICH INCLUDES 01-JAN-08 THROUGH 31-DEC-08

Column A	Column B	Column C	Column C-1	Column D	Column E
WAIVER SERVICES	# UNDUP RECIPIENTS USING SRVC	AVERAGE ANNUAL UNITS/USER	UNIT TYPE	AVERAGE COST/UNIT	TOTAL (B x C x D)
HOMEMAKER/PERSONAL CARE (HPC) - HOUR	4686	1198	HOUR	\$21.93	\$123,138,644
HOMEMAKER/PERSONAL CARE (HPC) - DAY	7271	192	DAY	\$133.79	\$186,789,578
SOCIAL WORK/COUNSELING	2263	39	HOUR	\$44.32	\$3,910,786
HOME-DELIVERED MEALS	10	198	1 MEAL	\$6.67	\$12,587
TRANSPORTATION	7024	1442	MILE	\$0.50	\$5,031,351
INTERPRETER	29	718	HOUR	\$18.48	\$379,505
NUTRITION	103	21	HOUR	\$57.43	\$124,198
SUPPORTED EMPLOYMENT	640	303	HOUR	\$19.79	\$3,836,733
ADAPTIVE/ASSISTIVE EQUIPMENT	960	2	ITEM	\$11,501.09	\$22,086,107
ENVIRONMENTAL MODIFICATION	477	1	ITEM	\$5,028.00	\$2,397,099
RESPIRE - DAY	183	29	DAY	\$179.15	\$951,117

Individual Options Waiver

VERSION 06-95

<u>GRAND TOTAL (sum of Column E):</u>	<u>\$ 348,657,705</u>
<u>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS :</u>	<u>9,535</u>
<u>FACTOR D (Divide grand total by the estimated number of unduplicated recipients)</u> <u>:</u>	<u>\$ 36,566</u>
<u>AVERAGE LENGTH OF STAY (in days) =</u>	<u>345</u>

STATE: Ohio

99
DATE: January 1, 2004

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

**Supported Employment
Nutrition
Interpreter
Social Work/Counseling
Home-Delivered Meals
Environmental Accessibility Adaptations
Specialized Medical Equipment and Supplies
Homemaker/Personal Care**

The services approved in the waiver are provided to individuals who live in a variety of settings, including residential settings and homes individuals themselves either own or rent. The individual's room and board is paid with the individual's personal resources and income. Incomes/personal resources may be subsidized with 100% State (Supported Living) funds or local funds are paid through a process that is separate from the payment of waiver services.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify): **None**

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, CMS published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

_____ Based on CMS Form 2082 (relevant pages attached).

 X Based on CMS Form 372 (**initial report**) for years 7/01 to 6/02 of waiver #0231.90 (IO), which serves a similar target population.

_____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_____ Other (specify):

STATE: Ohio

DATE: January 1, 2004

FACTOR D' EXPLANATION OF ADJUSTMENTS

Projected Annual Average Per Capita Medicaid Cost for All Other Services Provided to Individuals in the Waiver Program (D') using items IV.B.1.b and VIII.B.1 from CMS-372 (initial report), dated 3/17/03 for reporting period 07/01/01 through 06/30/02 for this waiver # 0231.90

CY02	CY03	CY04 (WY1)	CY05 (WY2)	CY06 (WY3)	CY07 (WY4)	CY08 (WY5)
	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%
\$15,046	\$15,272	\$15,501	\$15,733	\$15,969	\$16,209	\$16,452

D' has been adjusted to include the cost of short term institutionalization which began after the persons first day of waiver service and ended before the end of the waiver year if the person returned to the waiver. The cost of short term institutionalization was derived from Item IV.B.1.b from CMS 372 (initial) for the period 7/1/01 through 6/30/02.

The Projected Average Per Capita Medicaid Cost for All Other Services Provided to Individuals in the Waiver Program is calculated as the cost of previous year multiplied by the inflation rate plus 1 (one).

APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

 X Based on institutional cost trends shown by CMS Form 2082 (MSIS). Attached is an explanation of any adjustments made to these numbers.

 Based on trends shown by CMS Form 372 for year of this waiver # , which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

 Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

 Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

 Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

FACTOR G - EXPLANATION OF ADJUSTMENTS MADE TO CMS-2082

The CMS-2082 for FFY-99, FFY-00 AND FFY-01 were used to establish the inflation rate for Factor G values. The CMS-2082 total cost for ICFs/MR is divided by the total number of ICF/MR recipients to determine the average ICF/MR cost per recipient for FFY-99, FFY00, and FFY01.

	FFY-99	FFY-00	FFY-01
Total cost for ICFs/MR =	\$541,975,258	\$556,327,978	\$526,949,222
# of ICF/MR recipients =	8,268	8,281	7,412
Total Cost / #recipients =	\$65,551	\$67,181	\$71,094

(CY 01)	(CY 02)	(CY 03)	WY1 (CY 04)	WY2 (CY 05)	WY3 (CY 06)	WY4 (CY 07)	WY5 (CY 08)
	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%	4.25%
\$ 71,094	\$ 74,115	\$ 77,265	\$ 80,549	\$ 83,973	\$ 87,541	\$ 91,262	\$ 95,140

The population served in ICF/MR facilities are of the same level of care as those persons receiving services from the HCBS waiver for persons with MR/DD.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

_____ Based on CMS Form 2082 (relevant pages attached).

 X Based on CMS Form 372 for years 7/01 to 6/02 of this waiver
#0231.90, which serves a similar target population.

_____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_____ Other (specify):

STATE: Ohio

DATE: January 1, 2004

FACTOR G' - EXPLANATION OF ADJUSTMENTS

Projected Annual Average Per Capita Medicaid Costs for All Other Services Provided to Individuals Served in the Waiver, were the waiver not granted (G') using CMS 372 (initial report) dated 3/17/03 for reporting period 07/01/01 through 6/30/02 for this waiver #0231.90.

CY 02	CY 03	WY1 CY 04	WY2 CY 05	WY3 CY 06	WY4 CY 07	WY5 CY 08
	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%
\$ 12,147	\$ 12,329	\$ 12,514	\$ 12,702	\$ 12,892	\$ 13,086	\$ 13,282

Item IV.B.1a CMS-372 for 07/01/01 through 06/30/02 for this waiver, #0231.90 was used as the basis of cost projections.

Projected Annual Average Per Capita Medicaid Costs for All other Services Provided to Individuals Served in the Waiver is calculated as the cost of previous year multiplied by the inflation are plus one (1).

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1

FACTOR D: \$ 33,127

FACTOR G: \$ 80,549

FACTOR D': \$ 15,501

FACTOR G': \$ 12,514

TOTAL: \$ 48,628 <

TOTAL: \$ 93,063

YEAR 2

FACTOR D: \$ 33,955

FACTOR G: \$ 83,973

FACTOR D': \$ 15,733

FACTOR G': \$ 12,702

TOTAL: \$ 49,688 <

TOTAL: \$ 96,674

YEAR 3

FACTOR D: \$ 34,804

FACTOR G: \$ 87,541

FACTOR D': \$ 15,969

FACTOR G': \$ 12,892

TOTAL: \$ 50,773 <

TOTAL: \$ 100,434

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC:

YEAR 4

FACTOR D: \$ 35,674

FACTOR G: \$ 91,262

FACTOR D': \$ 16,209

FACTOR G': \$ 13,086

TOTAL: \$ 51,883 \leq

TOTAL: \$ 104,348

YEAR 5

FACTOR D: \$ 36,566

FACTOR G: \$ 95,140

FACTOR D': \$ 16,452

FACTOR G': \$ 13,282

TOTAL: \$ 53,018 \leq

TOTAL: \$ 108,423

STATE: Ohio

DATE: January 1, 2004