Regulations Implementing

The Developmental Disabilities Act of 1996

July 2007

Division of Disability and Aging Services
Vermont Department of Disabilities, Aging and Independent Living
July 3, 2007

Department of Disabilities, Aging and Independent Living
Regulations Implementing the Developmental Disabilities Act of 1996

Part 1. Definition of developmental disability and criteria for determining developmental disability

"Young child" means a child who is not yet old enough to enter first grade.

"School-age child" means a child who is old enough to enter first grade and younger than age eighteen.

"Adult" means a person age eighteen or older. The term includes people age eighteen or older who attend school.

Young Children

1.01 "Person with a developmental disability" defined (young children).

A young child with a developmental disability is a child who has:

(1) A condition which has a high probability of resulting in mental retardation (See Section 1.02); or

(2) Significant delays in cognitive development and adaptive behavior (See Section 1.03); or

(3) A pervasive developmental disorder resulting in significant delays in adaptive behavior. (See Section 1.05).

1.02 "Condition which has a high probability of resulting in mental retardation" defined (young children).

This means a diagnosed physical or mental condition, and includes but is not limited to the following:

Anoxia
Degenerative central nervous system disease (such as Tay Sachs syndrome)
Encephalitis
Fetal alcohol syndrome
Fragile X syndrome
Inborn errors of metabolism (such as untreated PKU)
Traumatic brain injury
Multisystem developmental disorder
Shaken baby syndrome
Trisomy 21, 18, and 13
Tuberous sclerosis

There must be a determination that, for the young child, the condition is so severe that there is a high probability that it will result in mental retardation.

1.03 "Significant delays in cognitive development and adaptive behavior" defined (young children).

(1) For young children, "significant delays in cognitive development and adaptive behavior" means clearly observable and measurable delays in cognitive development; and substantial observable and measurable delays in at least two of the following areas:

communication
social/emotional development
motor development
daily living skills

(2) For young children with a pervasive developmental disorder, "significant delays in adaptive behavior" means observable and measurable delays in at least two of the following areas:

communication
social/emotional development
motor development
daily living skills

1.04 Criteria for assessing developmental disability (young children).

(1) The diagnosis of "a condition which has a high probability of resulting in mental retardation" (See Section 1.02) must be made by a physician or licensed psychologist.

(2) The documentation of "significant delays in cognitive and adaptive behavior" (See Section 1.03) shall be made through a family-centered evaluation process which uses

(a) observations and reports by the family and other members of the assessment team. The assessment team shall include the family and a representative from a developmental services agency and one or more of the following, with parental consent: physician, behavior consultant, psychologist, speech therapist, physical therapist, occupational therapist, advocate, representative from the Family, Infant and Toddler Program, representative from Early Essential Education (EEE), representative from Children with Special Health Needs;

(b) a review of pertinent medical/educational records, as needed; and

(c) appropriate screening and assessment instruments.

Pervasive Developmental Disorders (all ages)

1.05 "Pervasive developmental disorder" defined.

"Pervasive developmental disorder" means one of the following disorders: autistic disorder, Rett's disorder, childhood disintegration disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

The diagnosis of pervasive developmental disorder is based upon the criteria contained in the Diagnostic and Statistical Manual (current edition).

1.06 Criteria for determining whether a person has a pervasive developmental disorder (all ages).

The diagnosis of a pervasive developmental disorder must be made by one of the following:

(1) A board certified or board eligible child and adolescent psychiatrist;

(2) A licensed psychologist who is specially trained to diagnose children;

(3) A board certified or board eligible pediatrician with additional training and experience in pediatric neurology, child psychiatry, or developmental pediatrics; or

(4) A physician or psychologist recognized by the Department as having training and experience in diagnosing pervasive developmental disorders.

School-Age Children and Adults

1.07 “Person with a developmental disability” defined (school-age children and adults).

A person with a developmental disability is a person who:

(1) Has mental retardation or a pervasive developmental disorder which occurred before age 18; and

(2) Has substantial deficits in adaptive behavior which occurred before age 18.

1.08 “Mental retardation” defined.

"Mental retardation" means significantly subaverage cognitive functioning documented by a full scale score of 70 or below on an appropriate standardized test of intelligence and resulting in substantial deficits in adaptive functioning.

"A score of 70 or below" means two standard deviations below the mean for a similiar age normative comparison group.

A person with a diagnosis of "learning impairment" has mental retardation if the person meets the criteria for "mental retardation" as that term is defined in these regulations.

"Mental retardation" includes severe cognitive deficits which result from brain injury or disease if the injury resulted in deficits in adaptive behavior before age 18. However, deficits in intellectual functioning which result from mental illnesses are not "mental retardation.'

1.09 Criteria for determining whether a person has mental retardation (school-age children and adults).

(1) The diagnosis of mental retardation must be made by a licensed psychologist who has personally performed, supervised, or reviewed assessments that document all three components of the diagnosis, specifically:

Significantly subaverage cognitive functioning (See paragraphs 2-5)
Resulting deficits in adaptive behavior (See section 1.10)
Onset before age 18 (See section 1.12)

"Licensed psychologist" means a licensed psychologist as defined in Title 26 of the Vermont Statutes, unless the psychologist falls within the specific exemptions of Section 3005 of that Title or a psychologist licensed under the laws of another state.

(2) The most universally used standardized intelligence test for school-aged children is the Wechsler Intelligence Scale for Children (WISC), current edition. The most universally used measure for adult intelligence testing is the Wechsler Adult Intelligence Scale (WAIS), current edition. For people with language, motor, or hearing disabilities, a combination of assessment methods should be used. Diagnosis based on interpretation of test results takes account of standard error of measurement for the test used.

(3) A diagnosis of mental retardation must be based upon current assessment of cognitive functioning. It is the responsibility of the psychologist to decide whether new cognitive testing is needed. In general, for school-aged children, "current" means testing conducted within the past three years. For adults, "current" means testing conducted in late adolescence or adulthood. Situations where new testing may be indicated include the following:

(a) There is reason to believe the original test was invalid (e.g., the person was sick, was not wearing glasses, was in the midst of a psychiatric crisis).

(b) The individual has learned new skills which would significantly affect performance (such as improved ability to communicate).

(c) The individual has mild mental retardation on a previous test and has since made gains in adaptive behavior.

(4) If past testing of the person has resulted in some scores above 70 and some scores below 70, it is the responsibility of the psychologist to determine which scores most accurately reflect the person’s cognitive ability. A diagnosis of mental retardation cannot be made if a person’s test scores are consistently greater than 70.

Diagnosis in questionable cases should be based upon scores over time and multiple sources of measurement.

(5) If the psychologist determines that standardized intellectual testing is inappropriate or unreliable for the person, the psychologist can made a clinical judgment based on other information, including an adaptive behavior instrument.

1.10 "Substantial deficits in adaptive behavior" defined (adults and school-age children).

"Substantial deficits in adaptive behavior" means deficits in adaptive function which result in:

(1) A composite score on a standardized adaptive behavior scale at least two standard deviations below the mean for a similar age normative comparison group, and also

(2) A score at least two standard deviations below the mean for a similar age normative comparison group in more than one of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, health, and safety.

A person who would have substantial deficits in adaptive behavior but for the fact that the person is receiving supports or services may be considered to be a person with substantial deficits in adaptive behavior.

1.11 Criteria for assessing adaptive behavior (adults and school-aged children)

(1) Adaptive functioning must be measured by a standardized norm-referenced assessment instrument, such as the Vineland Adaptive Behavioral Scale or the Woodcock
Johnson Scales of Independent Behavior. The assessment tool must be standardized with reference to people of similar age in the general population. (Do no use an instrument which is norm-referenced only to people in institutions or people with mental retardation).

(2) The assessment instrument must be completed by a person qualified to administer, score, and interpret the results as specified in the assessment tool's manual.

(3) The assessment must be current. A current assessment is one which was completed within the past three years, unless there is reason to think the individual's adaptive functioning has changed.

(4) Based upon the assessment, the evaluator must determine whether the person is performing two or more standard deviations below the mean with respect to adaptive functioning, compared to a national sample of similar-aged people.

1.12 "Occurred before age 18" defined.

"Occurred before age 18" means that impairment and resulting deficits in adaptive behavior occurred before age eighteen.

The onset in adulthood of impaired intellectual or adaptive functioning due to drugs, accident, disease, emotional disturbance, or the like, does not constitute a developmental disability.

Evidence that the impairment and resulting deficits in adaptive behavior occurred before the age 18 may be based upon records, information provided by the individual, and/or information provided by people who knew the individual in the past.

1.13 Nondiscrimination in assessment.

Assessment tools and methods shall be selected to meet the individual needs and abilities of the person being assessed.

(1) People whose background or culture differs from the general population shall be assessed with methods and instruments that take account of the person's background.

(2) A person shall be assessed in the language with which s/he communicates most comfortably.

(3) People with language, motor, and hearing disabilities shall be assessed with tests which do not rely upon language, motor ability, or hearing, such as the Test of Nonverbal Intelligence (TONI).

(4) If a person uses hearing aids, glasses, or other adaptive equipment to see, hear, or communicate, the evaluator shall assure that the individual has access to the aids or adaptive equipment during the evaluation.

(5) If a person uses an interpreter or personal assistant for communication (such as a person who uses sign language or facilitated communication), the evaluator (e.g., the psychologist) is responsible for deciding how best to conduct the overall assessment in order to achieve the most authentic and valid results. However, scores for standardized tests are valid only if testing was performed in accordance with the criteria set forth in the test manual.

1.14 People receiving services on July 1, 1996.

People with developmental disabilities and families who are receiving services on July 1, 1996, shall continue to receive services consistent with their needs and the system of care plan.

Part 2. Criteria For Being a "Recipient"

2.01 "Recipient" defined.

A "recipient" is a person who receives services, supports, vouchers, or cash benefits funded by the Division of Developmental Services.

2.02 Who can be a recipient.

A recipient must be either:

(1) A person with a developmental disability; or

(2) A family member who supports a person with a developmental disability.

Services or supports to a family member are in the context of supporting the person with a developmental disability and are for the purpose of assisting the family to provide care and support for their family member with a disability.

2.03 Recipients must be Vermont residents.

(1) A recipient must be a resident of Vermont. In the case of a minor child, at least one custodial parent of the child must be a resident of Vermont.

(2) A person or family who leaves Vermont for a vacation, visit, temporary move, or trial move, may continue to be a recipient for a period not to exceed one year.

2.04 Exceptions.

The Commissioner may make exceptions to the requirements of Sections 2.02 and 2.03 to promote the purposes of the Act if the exception will not deprive people who meet the criteria for being recipients of needed services or benefits (e.g., when matching funds are provided by another state, or by another department or agency).

Part 3. Definitions

The following terms are defined for the purpose of these regulations.

3.01 Department.

"Department" means the Department of Developmental and Mental Health Services.

3.02 Division.

"Division" means the Division of Developmental Services of the Department of Developmental and Mental Health Services.

3.03 Commissioner.

"Commissioner" means the Commissioner of the Department.

3.04 Designated agency.

"Designated agency" means the single organization designated by the Commissioner, pursuant to 18 VSA Section 8911, and the regulations implementing that law, to oversee the delivery of services for people with developmental disabilities in a geographic area of the state.

A list of the designated agencies for developmental services shall be available from the Department.

3.05 Specialized service agency.

"Specialized service agency" means an organization that receives direct funding from the Department to provide services to specified individuals. A specialized service agency must meet the criteria for being a certified provider and also the specific criteria for contracting with the Department as a specialized service agency described in the Department's administrative rules on agency designation (1998).

3.06 Agency.

"Agency" means the responsible designated agency or specialized service agency.

3.07 Certified provider or provider.

"Certified provider" or "provider" means an organization that is certified in accordance with Part 4 of these regulations as meeting minimum standards to receive state or federal funds administered by the Division to provide supports or services to people with developmental disabilities and/or their families. The term, where applicable, includes a specialized service agency and a designated agency which is certified to provide supports or services.

3.08 Applicant.

"Applicant" means a person who files a written application for services, supports or benefits in accordance with Part 5 of these regulations. If the applicant is a guardian or family member or designated agency, the term "applicant" also includes the person with a developmental disability.

3.09 Recipient.

"Recipient" means a person or family who meets the criteria contained in Part 2 of these regulations, and who has been authorized to receive funding or services pursuant to Section 5.08.

3.10 Terms deemed inclusive of guardian.

Unless otherwise specified, any reference to an applicant, recipient, person or individual is deemed to refer to the person's guardian, if the person has a guardian and if the action or notification lies within the authority of the guardian.

3.11 System of care plan.

"System of care plan" means the plan required by 18 V.S.A. Section 8725 describing the nature, extent, allocation and timing of services that will be provided to people with developmental disabilities and their families.

3.12 Day.

"Day" means calendar day, not working day.

Part 4. Certification of Providers

4.01 Definitions.

"Certification" means the process by which the Division determines whether a provider meets minimum standards for receiving funds administered by the Division to provide services or supports to people with developmental disabilities.

“Organization" means a corporation that has as one of its primary purposes to provide services and supports for people with developmental disabilities. The Division may waive certification, in whole or in part, for an organization licensed by another department of the State of Vermont.

A "provider" is an organization that is seeking or has received certification by the Division.

4.02 Purpose of certification.

The Developmental Disabilities Act of 1996, 18 V.S.A. Section 8730, requires the Department to establish standards and procedures for certification of all programs which receive funds administered by the Department to provide services or supports to people with developmental disabilities.

Other state or private funding sources may require certification as a condition of funding a program for people with developmental disabilities.

Certification is a method to assure that supports and services for Vermonters with developmental disabilities are consistent with the expectations of individuals receiving services and/or supports, the System of Care Plan, the Department, and the Developmental Disabilities Act of 1996.

Any organization that receives state and/or federal funds administered by the Division must be certified by the Division or operate under contract or subcontract with a certified organization.

Certification and designation (see Part 3) are separate and distinct processes. An organization may be certified without being a designated agency. Conversely, an organization may be a designated agency without being a certified provider.

4.03 Application for certification.

Organizations seeking initial certification must submit a written application to the Division. Providers seeking recertification must apply to the Division 90 days prior to the end of any existing certification.

The Division will specify the format and procedures for applications for certification and recertification.

The Division must send the applicant a written determination within 90 days after receiving an application for certification or recertification. An organization must be certified in order to receive funds administered by the Division.

4.04 Areas of certification.

Providers may apply to be certified in one or more of the areas noted below. The area of certification is based on the intent of the services/supports.

(1) Home Supports -- provision of residential supports up to 24-hours-per-day including supports to people in and around their homes, and in their neighborhoods and communities. This area includes certification that the provider has the capacity to furnish crisis support for all individuals who receive home support services.

(2) Community/Social Supports -- provision of supports to assist people with developmental disabilities to build relationships and be participating members of their communities.

(3) Work Supports -- provision of supports that assist people with developmental disabilities to secure employer-paid employment.

(4) Support Coordination -- provision of supports that help people with developmental disabilities and their families coordinate services, direct their own services, find and access supports and services, navigate the system, and/or adapt or design services to meet individual needs.

(5) Family Support -- provision of supports that help people with developmental disabilities live at home with their families. Certification for family support includes certification that the provider is capable of providing crisis support for all individuals and families who receive family support services.

(6) Crisis Support -- provision of specialized or comprehensive local, regional, or state crisis supports.

(7) Other -- provision of other supports/services not specified above. The provider must identify the specific support/service for which it is seeking certification.

4.05 Certification status/duration of certification.

(1) Current providers. Any provider in existence on the effective date of these regulations will be presumed to be certified for a period of up to one year. During this period, the Division will review each provider, and grant regular certification, probationary certification, or no certification in each of the areas for which the provider has applied to be certified.

(2) Regular certification or recertification. When the Division determines that a provider is willing and able to meet certification criteria and provides services consistent with the local and state system of care plans, a provider may be certified for one year. The period of certification may be extended for up to three years in cases of outstanding performance. The duration of certification is dependent upon the level and degree to which the provider meets the certification criteria and its willingness and ability to correct/improve deficiencies.

The Division makes the final decision as to whether an organization should be certified. The Division will offer the designated agency for each region in which a provider will operate an opportunity to comment about whether a provider is needed and should be certified. The Division will consider the

recommendations of the designated agency for the region or regions, as well as input from people with developmental disabilities, family members, and other interested people, and will investigate or consider any concerns related to whether the organization should be certified.

(3) Probationary certification. Probationary certification is used to evaluate a new provider's willingness and ability to meet certification criteria, and also to bring the performance of an existing provider with numerous or serious deficiencies up to minimum certification criteria. An organization with probationary certification receives intense review during the period of probation.

All new providers will be on probationary certification status for a period of at least one year. Any decertified provider seeking certification will be treated as a new provider.

A provider with probationary certification may be decertified at any time for failure to meet one or more certification criteria. Probationary certification may be granted with or without specific conditions.

Any certified provider may be placed on probationary certification in one or more areas of certification. Placement on probationary certification status may happen during the recertification process or at other such time as determined necessary by the Division.

A decision to place a provider on probationary certification is appealable to the Commissioner within 15 days of the date the provider receives written notification of probationary status. The Commissioner's decision regarding a probationary status appeal is final.

(4) Decertification. A provider may be decertified as follows:

(a) Immediate decertification. If a provider knowingly disregards or neglects policies or practices and the result is endangerment of the health or safety of an individual with developmental disabilities, violation of an individual's human or civil rights, severe or intentional fiscal irresponsibility, or falsification of data/record keeping, a provider may be immediately decertified.

(b) Decertification for failure to improve. If the provider exhibits unwillingness or inability to improve performance while on probation, as measured by certification criteria and within time frames established by the Division, a provider may be decertified.

A decision by the Division to decertify may be appealed to the Commissioner within 15 days of receipt of written notice of the decision. The Commissioner's decision regarding the decision to decertify is final. If decertification is due to endangerment of the health or safety of one or more people with developmental disabilities, the de-certification will be effective on the date of notice, pending the appeal process.

(5) Protection for individuals when a provider is decertified or certification lapses. If necessary for the orderly transition and protection of individuals served, the Division may provide funding for a transitional period to a provider which has lost its certification or has failed to request recertification.

(6) A provider is subject to unannounced monitoring visits by the Division at any time, regardless of certification status.

4.06 Organizational requirements for certification.

In order to be certified, a provider must meet the following organizational requirements:

(1) Incorporation. An organization must be incorporated to do business in the State of Vermont as a nonprofit organization, and have received or applied for federal recognition as a tax-exempt charitable organization as defined in Section 501(c)(3) of the Internal Revenue Code of the United States.

(2) Governance. An organization must have by-laws and a plan for governance and administration that includes a board of directors that consists of citizens who are representative of the general locale and individuals served. The board of directors shall have the powers ordinarily invested in a board of directors, including hiring, evaluation, and termination of the executive director; oversight of budget, operations and property; and assessment of quality of services.

(3) Policy input from people with developmental disabilities and their natural or adoptive families. If 50 per cent or fewer of the directors are people with developmental disabilities or their family members, the by-laws of the organization shall provide for a standing committee of the board. At least 25 per cent of the standing committee shall be people with developmental disabilities, and a majority of the standing committee shall be either people with developmental disabilities or family members.

The standing committee (or board of directors, if a majority of its members are people with developmental disabilities or family members) shall do the following:

(a) Evaluate the performance of the provider.

(b) Recommend or set policy regarding services.

(c) Participate in the selection and evaluation of key managerial staff.

(d) Assess the quality and responsiveness of services, and make recommendations as indicated.

(e) Review the efficiency and effectiveness of the provider’s financial and human resources.

(f) Participate with the designated agency in the development and design of services and supports and in development of the local and state system of care plans.

(g) Participate in and evaluate the provider's complaint resolution process in a manner that is respectful of individual confidentiality, and as required by Part 9 of these regulations.

(h) Report its findings and recommendations to the board of directors and to the Division.

Note: If an organization is both a designated agency and a certified provider, the requirements of subsections (2) and (3) are fulfilled by the designated agency's board of directors and standing committee.

(4) Fiscal management. In order to be certified, a provider must:

(a) have fiscal management practices which demonstrate fiscal solvency as defined by the Division, including the ability to meet payroll and pay bills and taxes due in a timely fashion.

(b) have the ability to monitor provider revenues and expenditures for each individual with developmental disabilities receiving service/support, by staff, service/support area and in total, in accordance with generally accepted accounting principles (GAAP).

(c) have proof of professional liability insurance, board/officer insurance, and general tort liability insurance within guidelines set by the Division.

(d) if it is an organization, engage an independent auditor to evaluate the financial records of the provider according to Division-established criteria.

Note: If an organization is both a designated agency and a certified provider, the financial accounting of the two entities must be clearly distinguished within the organization.

(5) Personnel Policies. To be certified, a provider must have written personnel policies and procedures that prohibit discrimination in accordance with federal and state law. The provider must have performance expectations and experience and education requirements for all positions, including contracted individuals. These requirements and criteria must reflect Department and Division mandates (such as minimum age, background checks, training) and must be sufficient to assure that workers meet the needs of individuals they are supporting.

(6) Accessibility. To be certified, a provider's offices, housing, transportation, communication, and other services or supports must meet state and federal requirements for accessibility and comply with the Americans with Disabilities Act as it relates to each individual served.

(7) Nondiscrimination. To be certified, a provider must comply with state and federal anti-discrimination laws and regulations.

4.07 Regional coordination.

To be certified, a provider must have a working agreement with the designated agency for the region or regions where it supports people. The agreement shall detail the roles and responsibilities of the two organizations regarding services and administrative functions, including information sharing and reporting, fiscal monitoring, periodic reviews, and support plan implementation.

Designated agencies are required to develop working agreements with certified providers or prospective certified providers, except when the designated agency has recommended to the Division, pursuant to Section 4.05(2), that a provider should not be certified, and the recommendation is under consideration by the Division.

4.08 Principles of service.

To be certified, a provider must have its mission and values consistent with the following principles contained in the Developmental Disabilities Act of 1996, 18 V.S.A., Section 8724, and must provide services/supports that foster and adhere to those principles:

(1) Children's Services. Children, regardless of the severity of their disability, need families and enduring relationships with adults in a nurturing home environment. The quality of life of children with developmental disabilities, their families and communities is enhanced by caring for children within their own homes. Children with disabilities benefit by growing up in their own families; families benefit by staying together; and communities benefit from the diversity that is provided when people with varying abilities are included.

(2) Adult Services. Adults, regardless of the severity of their disability, can make decisions for themselves, can live in typical homes and can contribute as citizens to the communities where they live.

(3) Full Information. In order to make good decisions, people with developmental disabilities and their families need complete information about the availability, choices and costs of services, how the decision making process works, and how to participate in that process.

(4) Individualized Support. People with developmental disabilities have differing abilities, needs and goals. To be effective and efficient, services must be individualized to the capacities, needs and values of each individual.

(5) Family Support. Effective family support services shall be designed and provided with respect and responsiveness to the unique needs, strengths and cultural values of each family and the family's expertise regarding its own needs.

(6) Meaningful Choices. People with developmental disabilities and their families cannot make good decisions without meaningful choices about how they live and the kinds of services they receive. Effective services shall be flexible so they can be individualized to support and accommodate personalized choices, values and needs and assure that each recipient is directly involved in decisions that affect that person's life.

(7) Community Participation. When people with disabilities are segregated from community life, all Vermonters are diminished. Community participation is increased when people with disabilities meet their everyday needs through resources available to all members of the community.

(8) Employment. The goal of job support is to obtain and maintain paid employment in regular employment settings.

(9) Accessibility. Services must be geographically available so that people with developmental disabilities and their families are not required to move to gain access to needed services, thereby forfeiting natural community support systems.

(10) Health and Safety. The safety and health of people with developmental disabilities is of paramount concern.

(11) Trained Staff. In order to assure that the goals of this section are attained, all individuals who provide services to people with developmental disabilities and their families must receive training as required by 18 V.S.A. Section 8731 and Part 10 of these regulations.

(12) Fiscal Integrity. The fiscal stability of the service system is dependent upon skillful and frugal management and sufficient resources to meet the needs of Vermonters with developmental disabilities.

4.09 Rights of individuals and families who receive services/supports.

To be certified, a provider must have a written policy stating its commitment to assuring the rights of all individuals and families who receive services/supports as stated in the Developmental Disabilities Act of 1996, 18 V.S.A. Section 8728. To be certified, a provider must provide services/supports that respect the rights of individuals and their families. The provider must assist individuals and families to understand the rights listed in this section as well as rights provided by state or federal law, and must provide this information in a format and language that is easy to understand.

(1) Every person with a developmental disability who receives services has the right to:

(a) Be free from aversive procedures, devices and treatments.

(b) Have privacy, dignity, confidentiality and humane care.

(c) Associate with individuals of both genders.

(d) Communicate in private by mail and telephone.

(e) Communicate in his or her primary language and primary mode of communication.

(f) Be free from retaliation for making a complaint, voicing a grievance, recommending changes in policies or exercising a legal right.

(g) Maintain contact with family, unless contact has been restricted by court order.

(h) Refuse or terminate services, except where services are required by court order.

(i) Have access to, read and challenge any information contained in any records about the person that are maintained by the Department or any agency or program funded by the Division and to file a written statement in the record regarding any portion of the record with which the person disagrees.

(2) Every family that receives services in the context of supporting a family member with a developmental disability has the right to:

(a) Receive services without relinquishing custody of a child or children except when custody is terminated in accordance with Vermont law.

(b) Privacy and confidentiality.

(c) Communication.

(d) Be free from retaliation for making a complaint, voicing a grievance, recommending a change in policy or exercising a legal right.

(3) People committed to the care of the Commissioner pursuant to subchapter 3 of chapter 206 of Title 18, relating to people who present a danger of harm to others, shall have all the rights provided by this section except when the Commissioner restricts those rights for reasons of safety, security or treatment.

4.10 Individual supports.

(1) Self-determination: Choice, Control, Satisfaction, Education. To be certified, a provider must:

(a) Assist people with developmental disabilities to make real choices by providing information and education to enable them to make informed choices.

(b) Support opportunities for individuals to participate in independent self-advocacy training, organized peer support and other advocacy activities.

(c) Respect the abilities of people with developmental disabilities to make decisions affecting their lives, with appropriate support, without the fear of retaliation.

(d) Have a quality improvement process that includes responding to information collected in individual and family satisfaction surveys.

(2) Support Planning. With the consent of the applicant or recipient, a certified provider shall participate in assessment, identification of supports, budget development and negotiation, and periodic review for each person and/or family it serves or has been asked to serve. (See Parts 5 and 6 of these regulations.) The provider shall enter into a written support agreement with each individual /or family it serves.

For each recipient, a certified provider must:

(a) Follow through with the support plan.

(b) Provide emotional support in times of crisis and conflict, and specific crisis supports if required by the area of certification.

(c) Provide, arrange, or assist the individual to access transportation that meets his/her needs, as identified by the individual in his/her support plan.

(d) Provide supports that respect the individual's need to be comfortable with the people who support him/her.

(e) Communicate in a manner the individual understands and uses.

(3) Healthy lifestyles. A certified provider must apply Division guidelines to an individual's specific health needs, including the following:

(a) Implement its role regarding health supports as stated in the individual's support plan.

(b) Involve medical guardians in decision making about an individual's health care.

(c) Demonstrate knowledge about the recipient's specific health concerns and medications.

(d) Assess, identify and respond to changes in health status, and the emotional and physical support needs of the recipient.

(e) Know how and when to seek appropriate medical services.

(f) Advocate for appropriate medical care and/or services, including second opinions or alternative therapies.

(g) Where applicable, implement the specialized care procedures described in Part 8 of these regulations.

(4) Safety and non-aversive practices. Any supports arranged, provided, or procured by the certified provider for a people with developmental disabilities must be provided in a safe environment, and in a non-aversive manner. A certified provider must:

(a) Apply Division standards regarding safety and healthy lifestyles to applicable locations where individuals with developmental disabilities receive services from or through the certified provider.

(b) Ensure appropriate supervision procedures are implemented as outlined in the individual's support plan.

(c) Implement appropriate procedures for emergency situations as they apply to each individual served.

(d) Provide service/support environments that are free from physical and emotional abuse, neglect or exploitation or the threat of physical and emotional abuse, neglect, or exploitation.

(e) Adhere to the Division policy regarding critical incident reporting and state laws concerning the reporting of abuse.

(f) Support individuals without resort to aversive practices, and adhere to Division guidelines addressing restrictive procedures.

4.11 Adherence to federal and state rules, regulations, policies and procedures.

To be certified, a provider must demonstrate knowledge of and ability to abide by state and federal rules, regulations, licensing requirements, policies and procedures relevant to the services/supports for which certification is sought.

4.12 Outcome performance.

To be certified, a provider must assure that individuals receiving services and/or supports receive them consistent with their individual support plan. Certified providers must also achieve provider performance outcomes in areas prioritized by the Division, the Department, and the Agency of Human Services.

4.13 Data and information systems.

To be certified, a provider must collect necessary and reliable data in a format and according to timelines set by the Division, and submit accurate information to the designated agency and/or the Division on costs, outcomes, consumer demographics, and types and frequencies of services and supports.

4.14 Confidentiality.

To be certified, a provider must protect the confidentiality of information about individuals with developmental disabilities and their families by:

(1) Conforming to all state and federal laws, regulations, and policies concerning confidentiality; and,

(2) Including in all contracts, language that explicitly states expectations about the confidentiality of information pertaining to applicants and recipients.

(3) Assuring that applicants, recipients, and former applicants and recipients have the opportunity to approve or refuse the release of identifiable personal information, except when such release is authorized or required by law or by state, federal or designated agency funding sources.

4.15 Complaints and appeals.

To be certified, a provider must have a written policy and procedures for complaints and appeals and for the dissemination of information on dispute resolution to individuals with developmental disabilities, consistent with Part 9 of these regulations.

To be certified, a provider must implement the decision of any mediator, arbitrator, panel, or Human Services Board, issued as the result of a complaint filed in accordance with Part 9 of these regulations.

4.16 System of care plans.

To be certified, a provider must participate in the development of the local and state system of care plans, and assist the Department and designated agency in involving people with developmental disabilities, families, staff and others who are associated with the provider in the development of those plans.

4.17 Training.

To be certified, a provider must implement training as required in Part 10 of these regulations and in Division training standards.

Part 5. Application, Assessment, Notification

5.01 Who may apply.

Any person who believes he or she has a developmental disability or is the family member of such a person may apply for services, supports, or benefits. In addition, the guardian of the person may apply.

Any other person may refer a person who may need services, supports, or benefits.

A designated agency may initiate an application for a person with a developmental disability or a family member, but must obtain the consent of the person or guardian to proceed with the application.

5.02 Application form.

The Division shall adopt an application form to be completed by or on behalf of all applicants.

Copies of the application form shall be available from the Department and from every office of a designated agency. A person may request an application form in person, by mail, by electronic mail, or by phone.

The designated agency shall provide assistance to an applicant who needs or wants help to complete the application form.

5.03 Where to apply.

An application shall be filed at an office of the designated agency for the geographic area where the person with a developmental disability lives.

An application may be submitted by mail, facsimile (FAX), electronic mail (e-mail) or in person.

5.04 Screening.

Within five working days of receiving an application, the designated agency shall complete the application screening process. The screening process includes all these steps:

(1) Explaining the application process to the applicant. This includes the information required, potential service options, how long the process will take, how and when the applicant will be notified of the decision, and the rights of applicants, including the right to appeal decisions made in the application process.

(2) Notifying the applicant of the rights of recipients, including the procedures for filing a complaint.

(3) Discussing options for information and referral.

(4) Determining whether the person with a developmental disability or the person's family is in crisis or will be in crisis within 60 days. If the designated agency determines that the person or

family is facing an immediate crisis, the designated agency shall make a temporary or expedited decision on the application.

5.05 Assessment.

The designated agency is responsible for conducting the assessment or assuring that it is conducted. The assessment process shall involve consultation with the applicant, and, with the consent of the applicant, other organizations which support the applicant, the certified provider (if any) which has been selected by the applicant.

The designated agency shall offer information and referral to the applicant at any time that it may be helpful.

Assessment consists of in-depth information-gathering to answer the four following questions:

(1) Is this a person with a developmental disability, as defined in Part 1 of these regulations, and a person eligible to be a recipient, as defined in Part 2? If so,

(2) What does the person or his/her family need? This question is answered through a uniform assessment process defined by the Department, which determines with each person or family their service or support needs, including identification of existing supports and family and community resources.

(3) Does the situation of the person or family meet the criteria for receiving any services or funding defined in the System of Care plan? If so,

(4) What are the financial resources of the person with a developmental disability and his or her family to pay for some or all of the services?

5.06 Authorization of funding.

Based on the answers to questions 1, 2, 3, and 4 in Section 5.05, the designated agency authorizes funding to meet identified needs. The funding amount authorized shall be equal to the amount needed to pay for any support needs requested by the applicant which fit within the state system of care priorities *minus* the amount the consumer or family is expected to pay (see Part 7) and *minus* supports or services available through other sources.

5.07 Notification.

Within 45 days of the date of the application, the designated agency shall notify the applicant in writing of the results of the assessment, and the amount of funding, if any, which the applicant will receive. The notice shall also state what costs, if any, the recipient is responsible to pay (see Part 7).

If the assessment and authorization of funding is not going to be complete within 45 days of the date of application, the designated agency shall notify the applicant in writing of the estimated date of completion of the assessment. A pattern of failure to complete the process within 45 days will be taken into account in determining whether to continue the designation of an agency.

If some or all services requested by the applicant are denied, the written notice shall include information about the basis for the decision, and how to appeal the decision, including:

(1) The policy or citations the action is based on (e.g., System of Care priorities);

(2) The right to appeal the decision and the procedures for doing so (see Part 9);

(3) Resources for legal representation (such as, Disability Law Project, South Royalton Legal Clinic).

If the assessment has determined that the person has a developmental disability but is not eligible to receive services or funding, the notification shall state that the designated agency will continue to offer information and referral services and will place the person's name on a waiting list.

5.08 Notices for people who cannot read.

The designated service agency shall assure that someone will explain the contents of any written notice to an applicant or recipient who cannot read.

5.09 Choice of provider.

The designated agency shall help a recipient learn about service options, including providers in the region who offer the services or supports the person or family has been determined to need. The designated agency must assure that at least one certified provider within the geographic area will offer the needed services at or below the authorized funding. If no such provider can be located, the designated agency must either increase the funding authorized or provide the service.

The recipient may choose to receive services from any provider certified to provide the needed service. If the designated agency thinks the certified provider is unable to meet the recipient's needs or otherwise disagrees with the choice of provider, the designated agency shall notify the recipient and explain to the recipient the reason for disagreement. If a designated agency refuses to contract with the certified provider of the recipient's choice, the recipient may request that the Director of the Division review the decision. The Director of the Division shall make a determination within 30 days of receiving the request for review. The decision of Director of the Division is final.

5.10 Support agreement.

Once a recipient has received written authorization of funding (Section 5.07), s/he then begins a process to define more specifically services and supports; the strategies for accessing the services or supports; the certified providers with which s/he wants to work; and the actual budget, which may not exceed the funding authorized by the designated agency. The recipient is the lead person in this process. The recipient may involve any person in the process.

The designated agency has ultimate responsibility to ensure that a support plan is developed within 30 days after the written authorization of funding or services, but this timeline may be extended at the request of the recipient.

The support plan is a contract between the recipient and provider(s) who will provide the service or support.

A support plan may be revised at any time, and must be reviewed at least annually.

5.11 Waiting list.

A person with a developmental disability whose application for services or supports is denied, in whole or in part, because the person's needs do not meet the System of Care Plan funding priorities, will be added to a waiting list maintained by the designated agency. The designated agency shall notify an applicant that his or her name has been added to the waiting list, and explain the rules for periodic review of the needs of people on the waiting list. (See Section 6.06)

Part 6. Periodic review

6.01 Annual or periodic review.

(1) At least annually, the responsible designated agency or specialized service agency shall review each recipient's budget and need for services. A specialized service agency shall review the budgets and services of recipients it serves under contract with the Department; all other recipients will be reviewed by the responsible designated agency in conjunction with the specialized service agency or certified provider for the person or family.

(2) The agency will make adjustments in a recipient's budget, if indicated, based upon the following:

(a) changes in the recipient's needs;

(b) changes in the cost of services to meet the needs; and

(c) changes in the state system of care plan.

(3) If there is reason to believe the person may no longer have substantial deficits in adaptive behavior, or may no longer have a developmental disability, the agency shall arrange for a reassessment in accordance with Sections 6.03 - 6.05. If a recipient's functional abilities have improved, the reassessment shall determine whether the person's functional abilities would decline if supports were removed.

(4) As part of the annual or periodic review, the agency shall ask each recipient about his or her satisfaction with services, and provide each recipient and guardian of a recipient with an explanation of the rights of recipients and how to initiate a complaint. (See Part 9)

(5) Questions about which agency is responsible for the periodic review will be resolved by the Division.

6.02 Change of agency.

If during a periodic review by a specialized service agency, a recipient chooses to receive some or all needed services or supports from a different provider, the specialized service agency shall transfer the individual's funds, together with responsibility for assisting the recipient to choose and access services, to the designated agency for the region.

6.03 Full reassessment (young children).

The designated or specialized service agency shall conduct or arrange for a full reassessment of a child at the time he or she enters first grade. The reassessment shall consider (1) whether the child is a person with a developmental disability, and (2) whether the support needs of the child and his or her family meet the funding criteria contained in Section 5.05. Assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.
If the reassessment determines that the child is no longer a person with a developmental disability, benefits for the child and family shall be phased out over a period of one year.

If the reassessment determines that the person or family no longer meet the criteria for receiving services or funding defined in the System of Care Plan, benefits for the child or family shall end. If the reassessment determines that the support needs of the person or family have changed or increased, the service agreement and budget shall be reviewed in accordance with Section 6.01.

6.04 Full reassessment (transition from school to adulthood).

The designated or specialized service agency shall conduct or arrange for a full reassessment of a recipient one year prior to his or her last month of school. The reassessment shall consider (1) whether the young adult is a person with a developmental disability and (2) the future service and support needs of the person and his or her family. Any assessments conducted by schools or other organizations should be used whenever possible to avoid duplication.

If the reassessment determines that the young adult is no longer a person with a developmental disability, services to the young adult and his or her family shall be phased out over a period of a year.

If the reassessment determines that the young adult or family no longer meet the criteria for receiving services or funding defined in the state system of care plan, benefits for the young adult or family shall end.

If the reassessment determines that the person or family will have changed or increased support needs when the young adult is no longer in school, funding and services shall be reviewed in accordance with Section 6.01.

6.05 Full reassessment (adults and children).

The designated or specialized service agency shall conduct or arrange for full reassessment of an adult if there is reason to believe the person may no longer have substantial deficits in adaptive behavior, or may no longer have a developmental disability.

If the reassessment determines that the individual is no longer a person with a developmental disability, the designated agency shall develop a plan to phase out services, and services to the person shall be phased out over the following year unless the individual is eligible to continue to receive services based on Section 1.14 (people receiving services on July 1, 1996) and Section 6.01(2).

6.06 Periodic review of need: waiting list.

The designated agency shall conduct or arrange for reassessment of a person on the waiting list upon being notified of a significant change in the person's life situation.

In addition, the agency shall review the needs of all people on the waiting list at least annually and when there are changes in the System of Care Plan funding priorities.

6.07 Notification of results of reassessment or review.

If a reassessment or review results in a determination that funding should be changed or end, the agency shall notify the recipient in writing of the results of the review or reassessment, and of the right

to appeal the decision. The notification shall be mailed at least 15 days prior to the planned change. However, the 15-day notice period may be waived or reduced if the recipient consents.

The notice must include the following:

(1) a statement of the action the agency intends to take;

(2) when it intends to take the action;

(3) the reasons for the intended action;

(4) the policy or citations on which the action is based (e.g., System of Care Plan);

(5) the right to appeal the decision and the procedures for doing so (see Section 9);

(6) a statement that services will continue at the current level if the appeal is filed in accordance with the timelines contained in Section 9.08;

(7) resources for legal representation (such as, Disability Law Project, South Royalton Legal Clinic).

6.08 Notices for people who cannot read.

The agency shall assure that someone will explain the contents of any written notice to a recipient who cannot read.

Part 7. Recipients Who Are Able to Pay

7.01 Services available regardless of funding source.

(1) Any services or supports which are provided to people who are eligible for Medicaid must be made available on the same basis to people who are able to pay for the services or who have other sources of payment.

(2) The rate charged to recipients who are able to pay for services or who have payment sources other than Medicaid must be the same as the rate charged to Medicaid-eligible recipients, *except that* the rate may be discounted to reflect lower administrative or implementation costs, if any, for non-Medicaid recipients. If a provider establishes a sliding fee scale for such services, the provider must have a source of funding (such as United Way, state funds, donated services) for the difference between the cost of providing the service and the fee charged.

(3) Any services not funded by Medicaid may be made available in accordance with a sliding fee schedule.

7.02 Income and resources; Medicaid-funded programs.

For all supports and services funded by Medicaid, the income and resource rules of the Department of Social Welfare governing eligibility for Medicaid programs apply, and are hereby incorporated by reference.

7.03 Room and board; personal spending money.

Medicaid Home and Community-Based Waiver funding does not cover room and board, clothing, and personal effects.

(1) At least annually, the Commissioner or his designee shall publish a schedule of rates for room and board and rates for personal spending allowances for recipients. The personal spending allowance shall not be less, and may be more, than the personal spending allowance for nursing home residents. The sum of the room and board rates and the personal spending allowance shall be equal to the current SSI rates, including state supplement.

(2) Payment of the rate set by the Commissioner's schedule shall be considered payment in full for the recipient's room and board if the recipient receives residential services funded by the Department. Recipients who receive income from a source other than SSI shall be charged the same rate for room and board as SSI recipients.

In unusual circumstances the Commissioner may permit non-Medicaid funds of the Department to be used to subsidize the excess costs of a recipient's room and board.

(3) Recipients who rent or own their own home or apartment, and have room and board costs in excess of the Commissioner's schedule shall receive assistance in accessing rent subsidy, low interest loans, fuel assistance, and other sources of housing assistance for low income Vermonters. To the extent authorized by the System of Care Plan, the Commissioner may

provide non-Medicaid funds to subsidize the excess costs of a recipient's rent or house payment, if the recipient is unable to afford the cost.

(4) A recipient who works may elect to use his or her earnings to pay rent or mortgage or room and board costs in excess of the Commissioner's schedule.

(5) The recipient, in consultation with his or her representative payee, if any, shall determine how to spend the personal spending allowance.

7.04 Responsibility of parents.

The parents of a child (under age 18) with a developmental disability are financially responsible for costs not covered by any Medicaid program or funded by the Department: specifically, housing, food, clothing, non-medical transportation, personal items, and child care necessary for a parent to work.

7.05 Notification of cost of services and recipient contribution policies.

(1) The designated agency shall notify every applicant of the cost of services and the requirements of these regulations with respect to recipient contribution.

(2) Annually, the designated agency shall notify every recipient of the cost of services and the requirements of these regulations with respect to recipient contribution.

Part 8. Special Care Procedures

8.01 Purpose.

The purpose of these regulations is to assure that people with developmental disabilities who have specialized health care needs will receive safe and competent care while living in home and community settings funded or certified by the Division.

People with developmental disabilities thrive best when their long-term care needs are met in individualized community-based homes, rather than in institutional settings. These regulations are intended to describe the training and monitoring needed when people with specialized health care needs live in non-institutional settings.

These regulations implement 18 V.S.A. Section 8732 of the Developmental Disabilities Act of 1996.

8.02 Effective date.

This Part is effective July 1, 1999.

8.03 Special care procedure defined.

The term "special care procedure" refers to nursing procedures which a lay individual (a person who is not a qualified health professional) does not typically have the training and experience to perform. The purpose for classifying a procedure as a "special care procedure" is to provide a system for assuring that lay people who provide special care procedures in home or community settings have the training and monitoring they need to protect the health and safety of the people they care for.

Examples of special care procedures are as follows:

(1) Enteral care procedures. Procedures that involve giving medications, hydration, and/or nutrition through a gastrostomy or jejunostomy tube. Special care procedures include replacement of G and J tubes, trouble-shooting a blocked tube, care of site, checking for placement, checking for residuals, use, care and maintenance of equipment; follow up regarding dietitians' recommendations, obtaining and following up lab work, mouth care, and care of formula.

(2) Procedures to administer oxygen therapy. Use of O2 tanks, regulators, humidification, concentrators, and compressed gas. This may include need for O2 assistance through use of SaO2 monitor, use of cannulas, tubing, and masks.

(3) Procedures that require suctioning techniques. Oropharyngeal (using Yankeur), nasopharyngeal (soft flexi tube) and tracheal components, which may include suctioning; clean versus sterile suctioning, care and maintenance of equipment, including stationary and portable systems.

(4) Administration of respiratory treatments. Using nebulizer set-up, care and maintenance of equipment.

(5) Tracheotomy care. Including cleaning of site and replacement of trach.

(6) Procedures that include placement of suprapubic and urethral catheters, intermittent catheterization, use and care of leg bags, drainage bags, when and how to flush, clean versus sterile catheterization.

(7) Procedures that include care of colostomy or ileostomy. Care of the stoma and maintenance of equipment.

(8) Diabetes care, including medications, use of insulin, how to monitor.

8.04 Application and limitations.

These regulations apply to organizations (including their staff and contractors) certified by the Division and/or compensated with funds administered or paid by the Division that provide supports or services to people with developmental disabilities.

These regulations do not apply to care provided in hospitals or nursing homes, nor do they apply to care provided by natural family members unless the family member is compensated for providing the care with funds administered or paid by the Division.

8.05 Determining that a procedure is a special care procedure.

The determination that a care procedure is a "special care procedure" has three components:

(1) The procedure requires specialized nursing skill or training not typically possessed by a lay individual;

(2) The procedure can be performed safely by a lay individual with appropriate training and supervision; and

(3) The person needing the procedure is stable in the sense that outcomes are predictable.

8.06 Who determines special care procedures.

The initial determination that a person may need a procedure requiring specialized skill or training may be made by the certified provider that serves the individual, by nursing staff of the Division, or by any other ancillary health providers.

A registered nurse determines whether a procedure is a special care procedure.

8.07 Who may perform a special care procedure.

A special care procedure may be performed only by a person over the age of 18 who receives training, demonstrates competence, and receives monitoring in accordance with these regulations.

Competence in performing a special care procedure is individualized to the particular needs, risks, and individual characteristics of a single individual. Thus, the fact that an employee or contractor may

have been approved to perform a special care procedure for one individual does not create or imply approval for that person to perform a similar procedure for another individual.

8.08 Specialized care plan.

If a registered nurse has determined that a person needs a special care procedure, the certified provider is responsible for ensuring that a specialized care plan is attached to the individual's support agreement.

The specialized care plan is developed by the registered nurse and must identify the specialized care procedures and the nurse responsible for providing training, determining competence, and reviewing competence. The specialized care plan must also include a schedule for the registered nurse to monitor the performance of specialized care procedures (See Sections 8.10 and 8.11).

8.09 Training.

(1) Qualifications of trainer. Training is provided by a registered nurse. The registered nurse must have a current State of Vermont nursing license.

(2) Timeliness. Training must be provided before any caregiver who is not a health professional provides a special care procedure without supervision. Training shall be provided in a timely manner so as not to impede services for an individual.

(3) Best practice. Training in special care procedures must conform to established best practice for performance of the procedure.

(4) Individual accommodations. Individuals with developmental disabilities have had unique experiences that may enhance or obstruct the ability to provide care. Within the framework of special care procedures, a combination of best practice and accommodation of individual characteristics will define the procedures to be used with a particular individual.

(5) Documentation of training. The certified provider responsible for the health needs of the individual is responsible for assuring that the registered nurse provides a record of training for any person who is carrying out a special care procedure. The records should include information about who provided the training, when the training was provided, who received training, what information was provided, and the conditions under which reassessment and retraining need to occur.

(6) Emergencies. The registered nurse must be notified of any changes in a person's condition or care providers. The certified provider responsible for the health needs of the individual must insure that special care procedures are performed by lay persons trained in accordance with the regulations, or else by nursing personnel.

8.10. Competence.

The determination of competence is a determination that a person demonstrates adequate knowledge to perform a task, including use of equipment and basic problem solving. Competence includes capability, and adequate understanding. Training and supervised practice pave the way for competence.

(1) Determination of competence. Determination of competence must be made by a registered nurse. The specialized care plan will identify the nurse responsible for making this determination.

(2) Supervised practice. An individual who is working toward but has not yet achieved status of a competent special care provider shall provide specialized care under the supervision of a registered nurse.

(3) Competence defined. Competence involves demonstrating safe performance of each step of the special care procedure and proper use and maintenance of equipment, basic problem solving, consistency of performance, and sufficient theoretical understanding.

(4) Documentation of competence. The record must document which people are determined competent to perform a special care procedure.

(5) Review of competence. A specialized care provider's competence should be reviewed by a registered nurse at least annually, and also when that worker's competence is in question, or at any time when there is change in the condition of the person with a developmental disability.

8.11 Monitoring.

Ongoing monitoring assures that a special care provider's skills and knowledge continue to be current. The individual's specialized care plan must include monitoring requirements, including expectations for monitoring the performance of special care procedures and patient outcomes at least yearly.

Part 9. Grievance and Appeal Procedures

9.01 Definitions.

(1) "Action" means an occurrence of one or more of the following by the agency for which an internal agency appeal may be requested:
a. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
b. reduction, suspension or termination of a previously authorized covered service or a service plan;
c. denial, in whole or in part, of payment for a covered service;
c. failure to provide a clinically indicated, covered service, when the provider is a state agency, or DA/SSA;
d. failure to act in a timely manner when required by state rule;
e. denial of a recipient's request to obtain covered services outside the network.

NOTE: A provider outside the network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.

(2) "Agency" for purposes of this section means a designated agency or a specialized service agency.

(3) "Appeal" means a request for an internal review of an action by the Department or agency.

(4) "Decision maker" means the person or persons empowered to make a decision under Sections 9.07 and 9.08.

(5) "Fair Hearing" means an appeal filed with the Human Services Board, whose procedures are specified in rules separate from the grievance and appeal process.

(6) "Filed" or "notified" means personally delivered, or deposited in the U.S. mail with first class postage affixed.

(7) "Grievance" means an expression of dissatisfaction about any matter that is not an action. Possible subjects for a grievance include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the recipient's rights. If a grievance is not acted upon within the timeframes specified in rule, the recipient may ask for an appeal under the definition above of an action as being a "failure to act in a timely manner when required by state rule." If a grievance is composed of a clear report of alleged physical harm or potential harm, the agency or Division will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulations board, Adult Protective Services).

(8) "Managed Care Organization" ("MCO") means:

1. a designated agency or a specialized services agency; and
2. the Department of Disabilities, Aging and Independent Living.

(9) "Network" means providers enrolled in the Vermont Medicaid program who are designated by the Commissioner of the Department of Disabilities, Aging and Independent Living and who provide services on an ongoing basis to recipients. It does not include a provider who enrolls on a one-time basis for the purpose of serving a specific recipient.

(10) "Provider" means a person, facility, institution, partnership or corporation licensed, certified or authorized by law to provide health care service to an individual during that individual's medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiary. A developmental home provider, employee of a provider, or an individual or family that self-manages services is not a provider for purposes of this rule.

(11) "Request for Reconsideration" means a process by which a recipient, provider or designated representative may request a review of an agency decision by the individual or entity that made the original decision. A request for reconsideration is not considered an appeal.

(12) "Service" means a benefit 1) covered under the 1115 Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Center for Medicare and Medicaid Services ("CMS"), 2) included in the State Medicaid Plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the Intergovernmental Agreement between the Office of Vermont Health Access and Agency of Human Services Departments or the Department of Education for the administration and operation of the Global Commitment to Health waiver.

9.02 General rules: confidentiality, no retaliation, notice.

(1) Confidentiality. All grievance and appeal proceedings will be confidential unless the applicant or recipient elects to make the proceedings public. If the applicant or recipient elects to make the proceedings public, s/he and the agency or Division must agree upon a method of maintaining the confidentiality of identifying information about any other people who may be referred to in testimony or other evidence.

(2) No retaliation. No agency shall retaliate against staff, applicants, recipients, or guardians who initiate or participate in the grievance and appeal process.

(3) Notice.

(a) The agency shall provide notice as described in Sections 4.09, 5.07, 5.08, 5.11, 6.01, 6.07, 6.08, and 9.08

(i) to an applicant, of the rights provided in the Developmental Disabilities Act, 18 VSA Sections 8727 (a) and 8728 and any other rights under state and federal law and the rights of grievance.

(b) All agencies and the Division shall post notices of the right to appeal and the procedure for appealing or initiating a grievance within the public areas of the agency. The Division shall provide such notices for posting, which shall include phone numbers for receiving help in initiating a grievance or appeal.

9.03 Next friend.

(1) A "next friend" is a friend, relative, advocate, human services professional or a concerned citizen with a close personal connection to the person with a developmental disability.

(2) A next friend shall be considered a duly appointed representative for purposes of resolving grievances and appeals.

(3) A next friend may initiate a grievance or appeal on behalf of a person with a developmental disability if the next friend believes the person is unable to initiate the grievance or appeal and

(a) the person has no guardian, or

(b) there is a conflict of interest between the person with a developmental disability and the person's guardian that has resulted in the guardian's failure to initiate a grievance or appeal.

(4) If the person has a guardian, the next friend must notify the guardian in writing when s/he initiates a grievance or appeal.

(5) If a grievance or appeal is initiated by a next friend, the decision maker shall review the need for a next friend and the ability of the person who initiated the grievance or appeal to serve in that role. If an alternate next friend is needed, the decision maker shall appoint an alternate.

9.04 Initiating a grievance.

(1) A grievance may be initiated by an applicant, a recipient, or the next friend of an applicant or recipient. A grievance may be expressed orally or in writing. A grievance must include a clear statement by the recipient that a written response is requested from the agency.

(2) Grievances must be filed within 60 days of the date the applicant or recipient received notice of the pertinent issue that is the basis of the grievance. Staff members must assist a recipient if the recipient or his or her representative requests such assistance. If the issue is about an ongoing situation of quality or accessibility or a delay in acting upon an application, a grievance shall be filed within 60 days of the time when the situation becomes unsatisfactory to the complainant

(3) All grievances shall be addressed within 90 calendar days of receipt. The decision-maker shall provide the recipient with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the recipient, the notice must also inform the recipient of his or her right to initiate a grievance review with the agency as well as information on how to initiate such review.

(4) If a grievance is decided in a manner adverse to the recipient, the recipient may request a review by the agency within 10 calendar days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.

(a) The agency shall acknowledge grievance review requests within five calendar days of receipt.

(b) The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The recipient shall be notified in writing of the finding of the grievance review.

(5) The agency and any part of the agency receiving funds for the provision of services under the Global Commitment to Health shall be responsible for resolving grievances initiated under these rules.

(6) Although the disposition of a grievance may not be appealed to the Human Services Board, the recipient may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V. S. A. §3091 (a).

9.05 Mediation.

(1) A recipient seeking a change in a decision of an agency may seek to resolve his or her dispute using mediation. Resolution of matters potentially subject to appeal using mediation must be completed within the initial 90 days that recipients have to file appeals. If the dispute can not be resolved by mediation, recipients may file an appeal with the agency. The appeal will be considered timely if the appeal is filed within the 90 days allowed for filing appeals. Resolution of grievances using mediation must be completed within 60 days.

(2) The Division shall arrange for independent mediation for people with developmental disabilities, their families, their guardians, next friends, and agencies involved in grievances and potential appeals. Mediation is a process in which a trained mediator assists parties in disagreement to arrive at a mutually agreeable resolution of the matters in dispute.

(3) Requests for mediation shall be in writing and submitted to Mediation Request, Division of Disability and Aging Services, Department of Disabilities, Aging and Independent Living, 103 South Main Street, Waterbury, VT 05671-1601.

(4) Requests for mediation may be filed jointly or by one party. In addition, the Division may suggest mediation to the parties to a dispute. Mediation may be requested prior to initiating an appeal or at any point in the process described in Section 9.07 prior to a final decision. Mediation can occur only when all parties involved in the dispute agree to engage in mediation.

(5) At the request of the parties, or with the agreement of the parties, the Division may be a party to mediation.

(6) The Division will assign an independent mediator within five working days of confirming that all parties agree to engage in mediation. Mediators will abide by professional mediation standards.

(7) Mediation may be ended at any time by any party or by the mediator. If the mediator ends the mediation, he or she may recommend an alternate method of dispute resolution to the parties.

(8) Each party to mediation shall assure that a person in attendance has decision-making authority for the party.

(9) If agreement is reached on some or all issues in dispute between the parties, that agreement shall be in writing and signed by all parties and the mediator. A mediation agreement is a final decision and is binding upon the parties unless the parties agree otherwise. A copy of the agreement shall be provided to the Division, and to any provider or agency which needs a copy of the agreement in order to implement it. The mediation agreement is a confidential record unless otherwise agreed by the parties.

(10) The mediation process is confidential. Therefore,

(a) the mediator shall not be called as a witness in any future administrative or court proceeding to testify regarding any information gained during the course of mediation; and

(b) statements made by a party at the mediation shall not be used at future administrative or court proceedings, except that information independently obtained may be used in a future administrative or court proceeding notwithstanding the fact that the information was discussed during mediation.

(11) The Division shall pay the cost of mediation.

(12) If a designated agency or specialized services agency fails to implement a mediation agreement, the Department may de-designate the agency.

9.06 Arbitration.

(1) A recipient seeking a change in a decision of an agency may resolve his or her dispute using arbitration. Resolution of matters in dispute using arbitration must be completed within the initial 90 days that recipients have to file appeals. If the recipient withdraws from the arbitration process prior to the Division determining that the parties understand that the decision of the arbitrator will be final and binding, the recipient may file an appeal with the agency. The appeal will be considered timely if it is filed within the 90 days allowed for filing appeals.

(2) Arbitration is a method of dispute resolution in which a trained arbitrator issues a decision based upon information and arguments presented by the parties. The decision of the arbitrator is final, and no final appeal of the arbitrator's decision can occur except as provided in Subsection 6. Thus, arbitration can be used only in situations where the parties understand and agree that the decision of the arbitrator will be final and binding. Arbitration is most suitable when less formal methods of dispute resolution have failed, or when a case involves complex issues of fact.

(3) A request for arbitration may be initiated by submitting a written request to Arbitration Request, Division of Disability and Aging Services, Department of Disabilities, Aging and Independent Living, 103 South Main Street, Waterbury, VT 05671-1601. A request for arbitration may be made at any point prior to the deadline for filing an appeal.

(4) The Division will assign an impartial arbitrator within five working days of determining that the parties agree or understand that the decision of the arbitrator will be final and binding.

(5) The arbitrator shall issue a final written decision within 60 days, unless the period is extended by agreement of all the parties. The arbitrator shall furnish a copy of the decision to all parties to the arbitration, to any agency which needs a copy in order to implement it, and to the Division. The arbitration decision is a confidential record unless otherwise agreed by the parties.

(6) If a party affected by the arbitration decision believes that the decision is contrary to federal or state law, or to the state or federal constitution, the party may, within 15 days of receiving the arbitrator's decision, request reconsideration of the arbitration decision by the arbitrator, citing the relevant statutory or constitutional provision. The arbitrator shall affirm or change the decision within 15 days of receipt of the request for reconsideration. This decision may be appealed only by a party who has a specific remedy at law. An arbitration decision is final and may not be appealed to the Human Services Board.

(7) The Department shall pay the arbitration costs.

(8) If a designated or specialized service agency fails to implement an arbitration decision, the Department may de-designate the agency.

9.07 Reconsideration.

If an applicant or recipient wishes to have an action by the agency or Department reconsidered, s/he may request the original decision-maker to reconsider the decision. A request for reconsideration does not suspend the 90 day timeframe for filing of appeals.

9.08 Initiating an appeal.

(1) When the agency issues an action subject to appeal, including a decision to deny, reduce, or terminate eligibility, or deny, reduce, or terminate services, or when an agency fails to act within 45 days upon an application for services, it shall notify the applicant or recipient of the right to appeal. Notice shall be provided as described in Section 5.07 or 6.07. In the event the agency fails to provide notice of appeal rights, the time limit for an applicant or recipient to submit an appeal shall be extended.

(a) An applicant or recipient who is dissatisfied with the decision of the agency may file an internal appeal through the agency and a request for a fair hearing before the Human Services Board. The request must be made within 90 days of the date of the initial decision. An applicant or recipient may use the internal agency appeal process while a fair hearing is pending or before a fair hearing is requested except when a benefit is denied, reduced or eliminated as mandated by federal or state law or rule, in which case the recipient must challenge the decision only by requesting a fair hearing.

(b) The agency shall notify the Department within one working day of receipt the request for appeal. The agency and the Department shall render a final MCO decision. The applicant or recipient shall have 30 days from the date of the final MCO decision to request a fair hearing.

(2) If requested by the applicant or recipient, services will be continued during an appeal regarding a Medicaid-covered health service termination or reduction if the appeal was filed in a timely manner, meaning before the effective date of the proposed action.

(3) The appeal process will include assistance by staff members, as needed, to the applicant or recipient to initiate and participate in the appeal. Applicants or recipients will not be subject to retribution or retaliation for appealing an agency or Department action.

(4) Applicants or recipients may file appeals orally or in writing. Appeals of agency or Department actions must be filed with the agency or Department within 90 days of the date of the notice of action. The date of the appeal, if mailed, is the postmark date.

(5) An initial applicant who files an appeal will not receive benefits pending the appeal.

(6) The Department shall have standing to be a party to any appeal filed with the Human Services Board.

(7) Appeals to the Human Services Board shall be conducted in accordance with the rules governing the conduct of fair hearings by the Human Services Board, 3 V.S.A. Section 3091.

(8) The fair hearing officer shall assure that the person with a developmental disability has access to legal representation, if desired.

(9) The fair hearing officer may order an independent evaluation at no cost to the person with a developmental disability if he or she finds that it would aid in resolution of the issue on appeal.

(10) The Human Services Board may reverse or modify a decision of the Department or an agency only if the decision is inconsistent with the System of Care Plan and the rules and policies of the Department. The Human Services Board shall not reverse a decision of the Department or agency if the decision is consistent with the System of Care Plan and the rules and policies of the Department, unless the Board finds that the System of Care Plan, rules, or policies of the Department conflict with state or federal law.

Part 10. Training

10.01 Purpose.

Training and technical assistance are ongoing processes that help ensure safety and quality services and reflect the principles of services of the Developmental Disabilities Act of 1996, generally accepted best practices, and the priorities of the system of care plan.

10.02 Definitions.

"Services" means direct care, support, respite, transportation, training of recipients, crisis services, referral, or intake funded by the Division.

“Worker” means any employee or contractee compensated with funds paid or administered by the Division to provide services to one or more people with a developmental disability. The term includes a worker’s supervisor. Professionals, such as nurses or psychologists practicing under a license granted by the State of Vermont are not included within this definition. Family-directed respite workers are not included within this definition.

"Family-directed respite worker" means a person who is employed or contracted and directed by a family and paid with Division funds to provide respite for a person with a developmental disability.

“Consumer-directed worker” means a person who is employed or contracted and directed by a person with a developmental disability and paid with Division funds to provide supports or services for the person with a developmental disability.

"Standards" are statements which describe the skills and knowledge required for workers, and timelines for acquiring the skills and knowledge.

"Pre-service training” means training that occurs prior to the time workers work alone with a person with developmental disabilities. Pre-service training provides workers with the minimum necessary skills to address the individual needs of the person or family for whom they provide services.

"In-service training" means training that occurs after a worker has been employed or is under contract. In-service training is intended to promote professional development and increase skills and knowledge.

"Technical assistance" means focused support and education regarding a specific individual or topic. Technical assistance is usually provided through consultation by someone with expertise in the area.

10.03 Division responsibilities.

By June 30, 1999, the Division shall:

(1) Adopt and implement a statewide training plan that supports and coordinates local training plans.

(2) Involve people with developmental disabilities and their families in the design, delivery and evaluation of training and technical assistance.

(3) Adopt standards in accordance with Section 10.05.

(4) Assure that each certified provider, specialized services agency, and designated agency adopts and implements a training plan, as specified in Sections 10.06 and 10.07.

(5) Monitor training plans as part of the certification and designation processes.

(6) Assure that all workers employed or contracted by the Division receive training consistent with these regulations.

10.04 Training advisory group.

At least annually, the Division shall convene a training advisory group consisting of people with disabilities, family members, advocates, service providers, Department staff, and others. The purpose of the training advisory group is to review and make recommendations to the Division regarding the content and effectiveness of standards, best practices and utilization of resources.

10.05 Standards.

Based upon recommendations of the training advisory group, the Division shall develop and periodically update standards designed to assure that workers:

(1) understand the values and philosophy underlying services and supports;

(2) acquire skills necessary to address the individual needs of the person or family for whom they provide service and support; and

(3) acquire skills to implement the principles and purposes of the Developmental Disabilities Act of 1996.

10.06 Designated agency responsibilities.

By June 30, 1999, each designated agency shall:

(1) Evaluate and address training needs in the region as part of the local system of care plan; and

(2) Require by contract that every service provider with which it contracts adopts and implements a training plan as specified in Section 10.07.

10.07 Provider and agency responsibilities.

(1) By June 30, 1999, each certified provider, specialized services agency, and designated agency shall adopt and implement a training plan which ensures, at a minimum, that:

(a) workers compensated with funds paid or administered by the provider or agency will

receive pre-service and in-service training or have knowledge and skills in the areas addressed by pre-service and in-service training consistent with Division standards and these regulations.

(b) workers, on an ongoing basis, have opportunities to broaden and develop their skills and knowledge in the following areas:

(1) best practices;

(2) values;

(3) current and emerging worker responsibilities; and

(4) current and emerging needs of the person with a developmental disability.

The training plan shall be based on assessment of the provider's or agency's ability to meet the needs of the people it serves, the local System of Care Plan, and the training needs of its staff and board members. The training plan shall be updated as needed but at least every three years.

(2) By June 30, 1999, each provider and agency shall:

(a) Have a system to verify that all workers (including contractors, subcontractors, employees of contractors, and consumer-directed workers) compensated with funds administered or paid by the organization have received pre-service and in-service training in accordance with these regulations, or have knowledge and skills in the areas addressed by pre-service and in-service training.

(b) Make pre-service and in-service training that is normally provided to staff available to contracted workers, family-directed respite workers, and consumer-directed workers at no cost to the family or consumer.

(c) Involve people with disabilities and their families in the design, delivery, and evaluation of training.

(d) Have a system to verify that all workers and also family-directed respite workers have been told about and understand the requirement to report abuse and neglect of children to the Department of Social and Rehabilitation Services, and abuse, neglect and exploitation of elderly or disabled adults to Adult Protective Services.

10.08 Family-directed workers.

The service provider shall:

(1) Inform each family that chooses to employ or contract with family-directed respite workers that the family is responsible for assuring that these workers receive information about the individual support needs and health and safety needs of the person with a developmental disability, and the abuse reporting requirements of Section 10.07(2)(d).

(2) Inform each family that chooses to employ or contract with family-directed respite workers of the availability of pre-service and in-service training for respite workers at no cost to the family.

10.09 Pre-service training.

Before working alone with a person who receives support funded by the Division, each worker must demonstrate knowledge or be trained in all of the following:

(1) Abuse reporting requirements:

(a) The requirements of Vermont law to report suspected abuse or neglect of children; and

(b) The requirements of Vermont law to report suspected abuse, neglect, or exploitation of elderly or disabled adults.

(2) Health and Safety:

(a) Emergency procedures, including where to locate the emergency fact sheet.

(b) What to do if the person is ill or injured.

(c) Critical incident reporting.

(d) How to contact a supervisor or emergency on-call staff.

(e) Other state or service provider policies regarding health, safety, and emergencies.

(3) Individual specific information. (The provisions of this sub-section will apply each time a worker works with a different person or family.)

(a) Whether the person has a guardian, and how to contact the guardian.

(b) The individual's behavior, including how to recognize and respond to stressors and behaviors which place the person or others at risk.

(c) Division medical guidelines.
(d) How to communicate with the person.

(e) The person's service/support plan, including the amount of supervision the person requires.

(4) Values:

(a) Individual rights.

(b) Confidentiality.

(c) Respectful interactions with people with developmental disabilities and their families.

(d) Principles of Service contained in the Developmental Disabilities Act of 1996.

(5) Other job specific information, as determined by the provider or agency and how to receive additional training or information (to be updated when a worker's responsibilities change).

10.10 In-service training.

Within three months of being hired or entering into a contract, workers shall be trained in or demonstrate the knowledge and skills necessary to support individuals, including:

(1) the skills necessary to implement the person's support plan,

(2) the service provider's mission,

(3) state and service provider policies and procedures, and

(4) basic first aid.

Workers shall be trained in blood-borne pathogens and universal precautions within time frames required by state and federal law.

10.11 Exception for emergencies.

For the purposes of this section, "emergency" means an extraordinary and unanticipated situation of fewer than 48 hours.

In an emergency, if the unavailability of a trained worker creates a health or safety risk for the person with a developmental disability, a worker who has not received pre-service training or demonstrated knowledge in all pre-service areas may be used for up to 48 hours. In this situation, the provider is responsible for assuring that essential information is communicated to the worker in brief form.