PART He-M 522 ELIGIBILITY AND THE PROCESS OF PROVIDING SERVICES FOR INDIVIDUALS WITH AN ACQUIRED BRAIN DISORDER

Statutory Authority: RSA 137-K:3

He-M 522.01 Purpose. The purpose of these rules is to establish standards and procedures for the determination of eligibility, the development of service agreements, and the provision and monitoring of services that maximize the ability and informed decision-making authority of persons with acquired brain disorder, and that promote the individual's personal development, independence, and quality of life in a manner that is determined by the individual.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18

He-M 522.02 Definitions.

(a) "Acquired brain disorder" means a disruption in brain functioning that:

(1) Is not congenital or caused by birth trauma;

(2) Presents a severe and life-long disabling condition which significantly impairs a person's ability to function in society;

(3) Occurs prior to age 60;

(4) Is attributable to one or more of the following reasons:

a. External trauma to the brain as a result of:

1. A motor vehicle incident;

2. A fall;

3. An assault; or

4. Another related traumatic incident or occurrence;

b. Anoxic or hypoxic injury to the brain such as from:

1. Cardiopulmonary arrest;

2. Carbon monoxide poisoning;

3. Airway obstruction;

4. Hemorrhage; or

5. Near drowning;

c. Infectious diseases such as encephalitis and meningitis;

d. Brain tumor;

e. Intracranial surgery;

f. Cerebrovascular disruption such as a stroke;

g. Toxic exposure; or

h. Other neurological disorders, such as Huntington's disease or multiple sclerosis, which predominantly affect the central nervous system resulting in diminished cognitive functioning and ability; and

(5) Is manifested by one or more of the following:

a. Significant decline in cognitive functioning and ability; or

b. Deterioration in:

1. Personality;

2. Impulse control;

3. Judgment;

4. Modulation of mood; or

5. Awareness of deficits.

(b) "Advanced crisis funding" means revenue authorized by the department of health and human services (department) when funds are not otherwise available for an individual who is in crisis as described in He-M 522.14(k) and requires services immediately.

(c) "Applicant" means any person who requests services pursuant to He-M 522.04.

(d) "Area agency" means "area agency" as defined in RSA 171-A:2, I-b.

(e) "Area agency director" means that person who is appointed as executive director or acting executive director of an area agency by the area agency's board of directors.

(f) "Assistive technology" means technology designed to be utilized in an "assistive technology device" as defined in 29 U.S.C. section 3002(4) or "assistive technology service" as defined in 29 U.S.C. section 3002(5).

(g) "Basic service agreement" means a written agreement between the individual, guardian, or representative and the area agency that is prepared pursuant to He-M 522.11 for each individual receiving services and that outlines the services and supports to be provided.

(h) "Brain Injury Community Supports" means services administered through the Brain Injury Association of New Hampshire that:

(1) Are provided to persons with an acquired brain disorder who are eligible for services pursuant to He-M 522.03 (a) but do not meet the eligibility criteria in He-M 517.03 (a) for Medicaid home- and community-based care; and

(2) Include, at a minimum the following services when such services are not reimbursable by Medicaid or other insurance:

a. Home modification;

b. Respite service;

c. Assistive technology;

d. Specialized equipment;

e. Transportation;

f. Short-term financial assistance, such as for utilities or rent;

g. Therapeutic evaluations; and

h. Other similar limited or nonrecurring services necessary for an individual to live as safely and independently as possible in his or her community.

(i) "Bureau" means the bureau of developmental services of the department of health and human services.

(j) "Bureau administrator" means the chief administrator of the bureau of developmental services.

(k) "Commissioner" means the commissioner of the department of health and human services or his or her designee.

(l) "Department" means the New Hampshire department of health and human services.

(m) "Developmental disability" means "developmental disability" as defined in RSA 171-A:2, V, namely, a disability:

(1) "Which is attributable to an intellectual disability, cerebral palsy, epilepsy, autism, or a specific learning disability, or any other condition of an individual found to be closely related to an intellectual disability as it refers to general intellectual functioning or impairment in adaptive behavior or requires treatment similar to that required for persons with an intellectual disability"; and

(2) "Which originates before such individual attains age 22, has continued or can be expected to continue indefinitely, and constitutes a severe disability to such individual's ability to function normally in society."

(n) "Direct and manage" means to be actively involved in all aspects of the service arrangement, including:

(1) Designing the services;

(2) Selecting the service providers;

(3) Deciding how the authorized funding is to be spent based on the needs identified in the individual's service agreement; and

(4) Performing ongoing oversight of the services provided.

(o) "Expanded service agreement" means a written agreement between the individual, guardian, or representative and the area agency that is prepared pursuant to He-M 522.11 and describes services pursuant to He-M 1001, He-M 521, He-M 525, He-M 507, and He-M 518.

(p) "Family support coordinator" means an area agency staff member who provides assistance to families in accordance with He-M 519.04.

(q) "Guardian" means a person appointed pursuant to RSA 463, RSA 464-A, or a parent or guardian of an individual under the age of 18 whose parental rights have not been terminated or limited by law in

such a way as to remove the parent or guardian's right to make decisions pursuant to RSA 171-A on behalf of the individual.

(r) "Health Risk Screening Tool (HRST)" means the 2015 edition of the Health Risk Screening tool, available as noted in Appendix A, which is a web-based rating instrument used for performing health risk screenings on individuals in order to:

(1) Determine an individual's vulnerability regarding potential health risks; and

(2) Enable the early identification of health issues and monitoring of health needs.

(s) "Home and community-based services" means medicaid services pursuant to He-M 517.

(t) "Individual" means a person with an acquired brain disorder who is eligible to receive services pursuant to He-M 522.03.

(u) "Informed consent" means a decision made voluntarily by an individual or applicant for services or, where appropriate, such person's legal guardian or representative, after all relevant information necessary to making the choice has been provided, when the person understands that he or she is free to choose or refuse any available alternative, when the person clearly indicates or expresses his or her choice, and when the choice is free from all coercion.

(v) "Intellectual disability" means "intellectual disability" as defined in RSA 171-A:2, XI-a, namely, "significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period. A person with an intellectual disability may be considered mentally ill provided that no person with an intellectual disability shall be considered mentally ill solely by virtue of his or her intellectual disability."

(w) "Local education agency (LEA)" means "local education agency" as defined in 34 CFR 300.28 and Ed 1102.03 (o).

(x) "Medicaid home- and community-based care services" means services provided in accordance to He-M 517.

(y) "Mental illness" means a condition of a person who is or has been determined severely mentally disabled in accordance with He-M 401.05 through He-M 401.07 and who has at least one of the following psychiatric disorders classified in the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition, Text Revision) (DSM-5), available as listed in Appendix A :

(1) Schizophrenia spectrum and other psychotic disorders, except for the following:

a. Schizotypal personality disorder;

b. Substance or medication induced psychotic disorder; and

c. Psychotic disorder due to another medical condition;

(2) Bipolar and related disorders, except for the following:

a. Substance or medication induced bipolar and related disorder; and

b. Bipolar disorder and related disorder due to another medical condition;

(3) Depressive disorders, except for the following:

a. Disruptive mood dysregulation disorder;

b. Premenstrual dysphoric disorder;

c. Substance or medication induced depressive disorder; and

d. Depressive disorder due to another medical condition;

(4) Borderline personality disorder;

(5) Panic disorder;

(6) Obsessive compulsive disorder;

(7) Post traumatic stress disorder;

(8) Bulimia nervosa;

(9) Anorexia nervosa;

(10) Other specific feeding or eating disorders;

(11) Unspecified feeding or eating disorders; and

(12) Major neurocognitive disorders where psychiatric symptom clusters cause significant functional impairment and one or more of the following symptom categories are the focus of psychiatric treatment:

a. Anxiety;

b. Depression;

c. Delusions;

d. Hallucinations;

e. Paranoia; and

f. Behavioral disturbance.

(z) "Participant directed and managed services" means services provided pursuant to He-M 525 whereby the individual or representative, if applicable, directs and manages the services, as defined in (n) above. Services include assistance and resources to individuals in order to maintain or improve their skills and experiences in living, working, socializing, and recreating.

(aa) "Personal profile" means a narrative description that includes:

(1) A personal statement from the individual and those who know him or her best that summarizes the individual's strengths and capacities, communication and learning style, challenges, needs, interests, and any health concerns, as well as the individual's hopes and dreams;

(2) A personal history covering significant life events, relationships, living arrangements, health, and use of assistive technology, and results of evaluations which contribute to an understanding of the person's needs;

(3) A review of the past year that:

a. Summarizes the individual's:

1. Personal achievements;

2. Relationships;

3. Degree of community involvement;

4. Challenging issues or behavior;

5. Health status and any changes in health; and

6. Safety considerations during the year;

b. Addresses the previous year's goals with a level of success and, if applicable, identifies any obstacles encountered;

c. Identifies the individual's goals for the coming year;

d. Identifies the type and amount of services the individual receives and the support services provided under each service category;

e. Identifies the individual's health needs;

f. Identifies the individual's safety needs;

g. Identifies any follow-up action needed on concerns and the persons responsible for the follow-up; and

h. Includes a statement of the individual's and guardian's satisfaction with services;

(4) An attached work history of the person's paid employment and volunteer positions, as applicable, that includes:

a. Dates of employment;

b. Type of work;

c. Hours worked per week; and

d. Reason for leaving, if applicable; and

(5) A reference to sensitive historical information in other sections of the chart when the individual, guardian, or representative, as applicable, prefers not to have this included in the profile.

(ab) "Provider" means a person receiving any form of remuneration for the provision of services to an individual.

(ac) "Provider agency" means an area agency or another entity under contract with an area agency to provide services.

(ad) "Region" means "area" as defined in RSA 171-A:2, I-a, namely, "a geographic region established by rules adopted by the commissioner for the purpose of providing services to developmentally disabled persons."

(ae) "Representative" means:

(1) The parent or guardian of an individual under the age of 18;

(2) The guardian of an individual 18 or over; or

(3) A person who has power of attorney for the individual granting specific authority to make the required decision.

(af) "Risk assessment" means an evaluation administered pursuant to He-M 522.10 (d)(13) using evidence-based tools to evaluate an individual's behaviors and determine the potential risks to the individual or others posed by said behaviors.

(ag) "Service" means any paid assistance to the individual in meeting his or her own needs provided through the area agency.

(ah) "Service agreement" means a written agreement between the individual, guardian, or representative and the area agency that was prepared as a result of the person-centered planning process and that describes the services that an individual will receive and constitutes an individual service agreement as defined in RSA 171-A:2, X. The term includes a basic service agreement for all individuals who receive services and an expanded service agreement for those who receive more complex services pursuant to He-M 522.11.

(ai) "Service coordinator" means a person who meets the criteria in He-M 522.09 (e)-(f) and is chosen or approved by an individual and his or her guardian or representative to organize, facilitate, and document service planning and to negotiate and monitor the provision of the individual's services and who is:

(1) An area agency service coordinator, family support coordinator, or any other area agency or provider agency employee who does not provide or have oversight of any direct services for the individual;

(2) A member of the individual's family;

(3) A friend of the individual; or

(4) Another person chosen to represent the individual.

(aj) "Service planning meeting" means a gathering of 2 or more people, one of whom is the individual who receives services unless he or she chooses not to attend, called to develop, review, add to, delete from, or otherwise change a service agreement.

(ak) "Specific learning disability" means a chronic condition of presumed neurological origin that selectively interferes with the development, integration, or demonstration of verbal or non-verbal abilities, and constitutes a severe disability to such individual's ability to function normally in society. The term includes such conditions as perceptual handicaps, brain injury, dyslexia, and developmental aphasia. The term does not include individuals who have learning problems which are primarily the result of visual, hearing, or motor handicaps, intellectual disability, emotional disturbance, or environmental, cultural, or economic disadvantage.

(al) "State of residence" means the state of residence as defined in 42 CFR 435.403.

(am) "Supports intensity scale (SIS)" means the 2004 edition of the Supports Intensity Scale, available as noted in Appendix A, which is an assessment tool intended to assist in service planning by measuring the individual's support needs in the areas of home living, community living, lifelong learning,

employment, health and safety, social activities, protection, and advocacy. The tool uses a formal rating scale to identify the type of supports needed, frequency of supports needed, and daily support time.

(an) "Termination" means the cessation of a service by an area agency director with or without the informed consent of the individual or his or her guardian or representative.

(ao) "Vacancy" means funds that become available when an individual stops receiving acquired brain disorder services.

(ap) "Wait list" means a list of individuals who need and are ready to receive services, are medicaid eligible, but who do not have funding for services needed.

(aq) "Withdrawal" means the choice of an individual or his or her guardian to discontinue that individual's participation in a service.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18

He-M 522.03 Eligibility for Services.

(a) As referenced in He-M 522.02(a) and (al), any person whose state of residence is New Hampshire and who has an acquired brain disorder shall be eligible for service coordination and community support.

(b) Individuals described in (a) above shall also be eligible for Medicaid home- and community-based care services if they meet the requirements of He-M 517.03(a).

(c) Any applicant for services whose suspected acquired brain disorder occurred prior to age 22 shall be evaluated pursuant to He-M 503.05 to determine whether he or she has a brain injury that meets the criteria for developmental disability. If the applicant has a developmental disability, he or she shall be provided services pursuant to He-M 503.09 and He-M 503.10. If the applicant is determined not to have a developmental disability, he or she shall be evaluated for eligibility pursuant to He-M 522.05.

(d) Eligibility for services shall be reviewed pursuant to He-M 522.07.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18

He-M 522.04 Application for Services.

(a) Application for services shall be made by:

(1) The applicant;

(2) A guardian of an applicant under the age of 18;

(3) A guardian of an applicant age 18 or over if a guardian of the person has been appointed by the probate court pursuant to RSA 464-A; or

(4) A representative of the applicant authorized to make such application.

(b) An application for services shall be made in writing to the area agency in the applicant's region of residence.

(c) An area agency shall explain the eligibility process and offer assistance to the applicant, guardian, or representative in making application for services.

(d) The area agency shall inform the applicant, guardian, or representative of its roles and responsibilities and provide information about:

(1) The types of evaluations, assessments, and screenings needed to assist in the development of the service agreement;

(2) Eligibility determination;

(3) Service coordination;

(4) Service agreement development and review;

(5) Services provided by the area agency and the assistance available to identify the services that are required;

(6) Service provision;

(7) Service monitoring; and

(8) Choice of provider for all services.

(e) An area agency shall request each applicant to authorize release of information to permit the area agency to access relevant current and historical records and information regarding the applicant's:

(1) Acquired brain disorder;

(2) Personal, family, social, educational, neuropsychological, medical, and rehabilitation status; and

(3) Functional abilities, interests, and aptitudes.

(f) Authorization to release information shall specify:

(1) The name of the applicant and the information to be released;

(2) The name of the person or organization being authorized to release the information;

(3) The name of the person or organization to whom the information is to be released; and

(4) The time period for which the authorization is given, which shall not exceed one year.

(g) To provide comprehensive, efficient, and coordinated services, the area agency shall undertake a review of the public and private benefits and resources that are available to the applicant.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18

He-M 522.05 Determination of Eligibility as a Person with an Acquired Brain Disorder.

(a) To determine the existence of an applicant's acquired brain disorder, the area agency shall perform an evaluation by:

(1) Completing a review of available assessments of the applicant's physical, intellectual, cognitive, and behavioral status and an age-appropriate standardized functional assessment; or

(2) If the information available is not adequate to make a determination, coordinating additional physical, neuropsychological, neurological, functional, and behavioral assessments and evaluations as necessary to make the determination.

(b) The results of the review and assessments pursuant to (a) above and any other information concerning the applicant's disability shall be the basis for determination of eligibility pursuant to He-M 522.03(a) and assist in the identification of needs and provision of services.

(c) To the extent possible, the area agency shall utilize generic resources to pay for an applicant's review and assessments. Such resources shall, with the applicant's consent, include private and public insurance.

(d) An area agency shall review the information it has received regarding an applicant and, within 15 business days after the receipt of the completed application, make a decision on the eligibility of the applicant in accordance with He-M 522.03(a). If the information required to determine eligibility cannot be obtained within these timelines, the area agency shall request an extension from the applicant, guardian, or representative, state the reason for the delay and obtain approval in writing. This extension shall not exceed 30 business days after the receipt of application.

(e) In cases where the information on eligibility is inconclusive, the area agency may consult the department regarding determination of eligibility. If it is anticipated that eligibility will not be determined within the timelines stated in (d) above, the area agency shall request an extension from the applicant, guardian, or representative, state the reason for the delay, and obtain approval in writing. This extension shall not exceed 30 business days after the receipt of application.

(f) If the area agency request for an extension pursuant to (d) or (e) above is denied by the applicant, guardian, or representative, the area agency shall determine the applicant to be ineligible for services. The applicant, representative, or guardian may reapply for services pursuant to (k) below.

(g) In an emergency situation, temporary service arrangements may be made prior to the completion of the eligibility determination process if the area agency director or designee and bureau administrator or designee first determine that the criteria in He-M 522.14(i) are met.

(h) For an applicant found eligible under He-M 522.03(a) for service coordination and brain injury community support, within 3 business days the area agency shall:

(1) Make a written referral to the department for additional determination of eligibility under He-M 522.06(a); and

(2) Notify the individual or guardian, if applicable, in writing regarding his or her eligibility for service coordination and that the application is being forwarded to the department for eligibility determination under He-M 522.06(a).

(i) Preliminary planning to determine the services needed shall occur with the individual and guardian or representative at the time of intake or during subsequent discussions. Preliminary evaluations shall be completed and preliminary recommendations for services shall be made within 21 days of application for service, or within 5 days of an eligibility determination made after extension pursuant to (d) or (e) above.

(j) Within 3 days of determination of an applicant's ineligibility, an area agency shall convey to the applicant, guardian, or representative a written decision that describes the specific legal and factual basis

for the denial, including specific citation of the applicable law or department rule(s), and advise the applicant in writing and verbally of his or her appeal rights under He-M 522.18.

(k) Following denial of eligibility, the applicant, , guardian, or representative, as applicable, may reapply for services if new information regarding the diagnosis, level of care, or severity of the disability or functional impairment related to the acquired brain disorder becomes available.

(l) The determination of eligibility by one area agency shall be controlling on any other area agency in the state.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18

He-M 522.06 Determination of Eligibility for Medicaid Home- and Community-based Care Services.

(a) For those persons found eligible under He-M 522.03(a), the department shall review the referral made pursuant to He-M 522.05(h)(1) and shall, within 15 business days of receipt of the referral, make a decision on eligibility under He-M 522.03(b). This decision shall be conveyed to the applicant and representative or guardian, if applicable, in writing and include the specific legal and factual basis for the determination, including specific citation of the applicable law or department rule.

(b) Within 3 business days of receipt of the department's determination regarding an applicant's eligibility under He-M 522.03(b), an area agency shall issue written notice to the applicant and guardian, if applicable, as follows:

(1) For an applicant eligible for services under He-M 522.03(b), notice shall include the name of the area agency contact person and state that the applicant is eligible under He-M 522.03(a) for service coordination and He-M 522.03(b) for medicaid home- and community-based care services;

(2) For an applicant not eligible under He-M 522.03(b), notice shall include:

a. The specific legal and factual basis for the determination, including specific citation of the applicable law or department rule; and

b. Written and verbal notice of the appeal rights under He-M 522.18.

(c) Following denial of eligibility, the individual, representative or guardian, as applicable, may reapply for services if new information regarding the diagnosis, level of care, or severity of the disability or functional impairment related to the acquired brain disorder becomes available.

(d) The determination of eligibility under He-M 522 by one area agency shall be controlling on every other area agency of the state.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18

He-M 522.07 Periodic Review of Eligibility.

(a) If there is reason to believe that the individual's level of cognitive functioning or adaptive behavior has changed and the person no longer has an acquired brain disorder as defined in He-M 522.02(a), or a need for services pursuant to He-M 517.03(a)(4)b., the area agency shall notify the individual receiving services, or the representative or guardian if the individual has one, and arrange for a reassessment of eligibility. The individual, representative, or guardian shall have the right to submit additional evaluations, letters, or other information regarding continued eligibility which shall be considered by the area agency or department prior to issuing a decision.

(b) If the results of the above reassessment demonstrate that the person no longer meets the criteria for eligibility in He-M 522.03(a) or (b), the area agency shall inform the person, representative, or guardian in writing of the determination and phase out the relevant services over the 12 months following the redetermination.

(c) In each instance where the reassessment leads to a denial of eligibility, the area agency shall in writing;

(1) Inform the applicant, guardian, or representative of the determination;

(2) Describe the specific legal and factual basis for the denial, including specific citation of the applicable law or department rule; and

(3) Advise the applicant, representative, or guardian of the appeal rights under He-M 522.18.

(d) A person or guardian may appeal a denial of eligibility based on redetermination pursuant to He-M 202.08 and He-C 200.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10 (from He-M 522.06); ss by #12683, eff 11-30-18

He-M 522.08 Service Guarantees.

(a) All services shall:

(1) Be voluntary;

(2) Be provided only after the informed consent of the individual, guardian, or representative;

(3) Comply with the rights of the individual established under He-M 310; and

(4) Facilitate as much as possible the individual's ability to determine and direct the services he or she will receive.

(b) All services shall be designed to:

(1) Promote the individual's personal development and quality of life in a manner that is determined by the individual;

(2) Meet the individual's needs in personal care, employment, and leisure activities;

(3) Meet the individual's needs in adult basic education:

a. Including educational activities with the purpose of assisting the individual in attaining or enhancing community living skills or adaptive skill development to assist the individual in residing in the most appropriate setting for his or her needs; and

b. Not including post-secondary education;

(4) Promote the individual's health and safety within the bounds of reasonable risk;

(5) Protect the individual's right to freedom from abuse, neglect, and exploitation;

(6) Increase the individual's participation in a variety of integrated activities and settings;

(7) Provide opportunities for the individual to exercise personal choice, independence, and autonomy within the bounds of reasonable risks;

(8) Enhance the individual's ability to perform personally meaningful or functional activities;

(9) Assist the individual to acquire and maintain life skills, such as, managing a personal budget, participating in meal preparation, or traveling safely in the community, including accessing community transportation; and

(10) Be provided in such a way that the individual is seen as a valued, contributing member of his or her community.

(c) The environment or setting in which an individual receives services shall be the least restrictive, most integrated setting that promotes that individual's:

(1) Freedom of movement;

(2) Ability to make informed decisions;

(3) Self-determination; and

(4) Participation in the community.

(d) An individual, guardian, or representative may select any person, provider agency, or another area agency as a provider to deliver one or more of the services identified in the individual's service agreement. The area agency shall provide information at intake and at a minimum at each annual service agreement meeting regarding choice.

(e) All providers shall comply with the rules pertaining to the service(s) offered and meet the provisions specified within the individual's service agreement. Providers shall also enter into a contractual agreement with the area agency and operate within the limits of funding authorized by it.

(f) After discussions with the individual, guardian, or representative and proposed or current provider, if the area agency determines that a provider chosen by the individual, guardian, or representative is a new provider that proposes a service arrangement which is not in accordance with department rules, or is a provider that has not been in compliance with department rules in the past, the area agency shall:

(1) Provide a written rationale to the individual, guardian, or representative stating the reasons why the area agency will not enter into a service contract with the provider; and

(2) With input from the individual, guardian, or representative, identify another provider.

(g) After discussions with the individual, guardian, or representative and proposed or current provider, if the area agency determines that a provider chosen by the individual, guardian, or representative

is not implementing the service agreement, providing for the health and safety of the individual, or in compliance with applicable rules while providing services, the area agency shall:

(1) Terminate the service contract with the provider with a 30 day notice; and

(2) With input from the individual, guardian, or representative, establish another service arrangement and amend the service agreement.

(h) If the area agency determines that a provider chosen by the individual, guardian, or representative is posing a serious threat to the health or safety of the individual, the area agency shall, with input from the individual, guardian, or representative, secure another provider and issue a notice to immediately terminate the service contract of the current provider, specifying the reasons for the action.

(i) The individual, guardian, or representative may appeal the area agency's decision under (e) or (f) above. At the time it provides notice, the area agency shall advise the individual, guardian, or representative in writing of his or her appeal rights under He-M 522.18.

(j) An area agency shall create service agreements for all individuals for whom funding for medicaid home- and community-based care services is available pursuant to He-M 517.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10 (from He-M 522.07); ss by #12683, eff 11-30-18 (formerly He-M 522.09)

He-M 522.09 Service Coordination.

(a) The service coordinator shall be a person chosen by the individual, guardian, or representative who meets the criteria in He-M 506.03(b)-(g) and He-M 522.09(e)-(f) below.

(b) The area agency shall advise the individual and guardian or representative in writing within 5 days of the determination of eligibility and each year prior to the annual service planning meeting under He-M 522.10 and He-M 522.11 that he or she has a right to choose his or her own service coordinator, including one who is not employed by the area agency.

(c) For those individuals not eligible for medicaid home- and community-based care services pursuant to He-M 517, the service coordinator shall:

(1) Hold a planning session to identify service needs and goals and appropriate community resources;

(2) Make appropriate referrals to community agencies; and

(3) Advocate on behalf of the individual for services to be provided in accordance with He-M 522.

(d) For those individuals eligible under He-M 517.03, the service coordinator shall:

(1) Advocate on behalf of individuals for services to be provided in accordance with He-M 522.08(b);

(2) Coordinate the service planning process in accordance with He-M 522.08, He-M 522.10, and He-M 522.11;

(3) Describe to the individual, guardian, or representative service provision options such as participant directed and managed services;

(4) Monitor and document services provided to the individual;

(5) Ensure continuity and quality of services provided;

(6) Ensure that service documentation is maintained pursuant to He-M 522.11 (c), (h)(1) and (m)(2)-(3);

(7) Determine and implement necessary action and document resolution when goals are not being addressed, support services are not being provided in accordance with the service agreement, or health or safety issues have arisen;

(8) Convene service planning meetings at least annually and whenever:

a. The individual, guardian, or representative is not satisfied with the services received;

b. There is no progress on the goals after follow-up interventions;

c. The individual's needs change;

d. There is a need for a new provider; or

e. The individual, guardian, or representative requests a meeting;

(9) Document service coordination visits and contacts pursuant to He-M 522.10(n) and He-M 522.11 (m)(2)-(4);

(10) In advance of the annual service planning meeting, either during the quarterly meeting held prior to the expiration of the service agreement or at least 45 days prior to the expiration of the service agreement:

a. Ensure that all needed evaluations, screenings, or assessments, such as the SIS, HRST, assistive technology evaluation, risk assessments, behavior plans, and other clinical or health evaluations are updated and, if necessary, performed and that information from said evaluations, screenings, and assessments is discussed and shared with the individual, guardian, or representative;

b. Identify risk factors and plans to minimize them;

c. Assess the individual's interest in, or satisfaction with, employment; and

d. Discuss and assess the individual's progress on goals and preparing for the development of new goals to be included in the new service agreement; and

(11) Assist the individual, guardian, or representative to maintain the individual's public benefits.

(e) A service coordinator shall not:

(1) Be a guardian or representative of the individual whose services he or she is coordinating;

(2) Have a felony conviction;

(3) Have been found to have abused or neglected an adult with a disability based on a protective investigation performed by the bureau of elderly and adult services in accordance with He-E 700 and an administrative hearing held pursuant to He-C 200, if such a hearing is requested;

(4) Be listed in the state registry of abuse and neglect pursuant to RSA 169-C:35 or RSA 161-F:49; or

(5) Have a conflict of interest concerning the individual, such as providing other direct services to the individual.

(f) If the service coordinator chosen by the individual, guardian, or representative is not employed by the area agency or its subcontractor:

(1) The service coordinator and area agency shall enter into an agreement which describes:

a. The role(s) set forth in He-M 522.09 for which the service coordinator assumes responsibility;

b. The reimbursement, if any, provided by the area agency to the service coordinator;

c. The oversight activities to be provided by the area agency; and

d. Compliance with (e) above;

(2) If the area agency determines that the service coordinator is not acting in the best interest of the individual or is not fulfilling his or her obligations as described in the letter of agreement, the area agency shall revoke the designation of the service coordinator with a 30-day notice and designate a new service coordinator, with input from the individual, guardian, or representative, pursuant to (a) above; and

(3) If the area agency determines that a service coordinator chosen by the individual, guardian, or representative is posing an immediate and serious threat to the health or safety of the individual, the area agency shall terminate the designation of the service coordinator immediately upon issuance of written notice specifying the reasons for the action and designate a new service coordinator, with input from the individual, guardian, or representative, pursuant to (a) above.

(g) The individual, guardian, or representative may appeal the area agency's decision under (f)(2) or (3) above about a service coordinator pursuant to He-M 522.18. At the time it provides notice under (f)(2) or (3) above, the area agency shall advise the individual, guardian, or representative in writing of his or her appeal rights under He-M 522.18.

(h) The role of service coordinator may, by mutual agreement, be shared by an employee of the area agency and another person. Such agreements shall be in writing and clearly indicate which functions each service coordinator will perform.

(i) For individuals who receive services from both the developmental services and behavioral health services systems, service coordination shall be billed only by the area agency or behavioral health agency that is the primary service provider, pursuant to He-M 426.15(a)(6).

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10 (from He-M 522.08); ss by #12683, eff 11-30-18 (formerly He-M 522.10)

He-M 522.10 Service Planning for Individuals Eligible for Medicaid Home- and Community-based Care Services.

(a) Within 5 days of the determination of eligibility, the area agency shall have conducted sufficient preliminary planning with the individual and the guardian or representative at the time of intake or during subsequent discussions to identify and document the specific services needed based on information obtained pursuant to He-M 522.05(a).

(b) The service coordinator shall hold an initial service planning meeting with the individual, the individual's guardian or representative, and any other person chosen by the individual within 30 days of the determination of eligibility.

(c) Service coordinators shall facilitate service planning to develop service agreements in accordance with He-M 522.11. Service agreements shall be prepared initially according to the timeframe specified in He-M 522.11(c) and annually thereafter, as required by He-M 522.09(d)(8).

(d) All service planning shall occur through a person-centered planning process that:

(1) Maximizes the decision-making of the individual;

(2) Is directed by the individual or the individual's guardian or representative;

(3) Facilitates personal choice by providing information and support to assist the individual to direct the process, including information describing:

a. The array of services and service providers available; and

b. Options regarding self-direction of services;

(4) Includes participants freely chosen by the individual;

(5) Reflects cultural considerations of the individual and is conducted in clearly understandable language and form;

(6) Occurs at a time and location of convenience to the individual, guardian, or representative;

(7) Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants;

(8) Is consistent with an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint;

(9) Includes a method for the individual, guardian, or representative to request amendments to the plan;

(10) Records the alternative medicaid home- and community-based settings that were considered by the individual, guardian, or representative;

(11) Includes information obtained through utilization of the SIS,for individuals aged 16 or older, which shall be administered:

a. Initially, for each individual receiving funded community participation services pursuant to He-M 507, community support services pursuant to He-M 517.05(k),

employment services pursuant to He-M 518, residential services pursuant to He-M 1001, residential and community support services provided in the family home pursuant to He-M 521, or participant-directed and managed services pursuant to He-M 525;

b. Upon an individual's entry onto the wait list;

c. Upon a significant change as defined under SIS protocols; and

d. Five years following each prior administration;

(12) Includes information obtained through the HRST, which shall be administered:

a. Within 30 days of the initiation of services;

b. Within one year of the effective date of these rules, for each individual receiving funded community participation services pursuant to He-M 507, community support services pursuant to He-M 517.05(k), employment services pursuant to He-M 518, residential services pursuant to He-M 1001, participant-directed and managed services pursuant to He-M 525, or in-home support services pursuant to He-M 524; and

c. Annually or upon significant change in an individual's status;

(13) Includes information obtained through a risk assessment, which shall be administered:

a. To each individual with a history of, or exhibiting signs of, behaviors that pose a potentially serious likelihood of danger to self or others, or a serious threat of substantial damage to real property, such as:

(i) Sexual offending;

(ii) Violent aggression;

(iii) Arson; or

(iv) Other similar violent or dangerous events;

b. Upon the earlier of said individual's entry onto the wait list or the individual's receiving services under He-M 500;

c. Prior to any significant change in the level of the individual's treatment or supervision;

d. At any time an individual who previously has not had a risk assessment begins to engage in behaviors referenced in a. above; and

e. By an evaluator with specialized experience, training, and expertise in the treatment of the types of behaviors referenced in a. above;

(14) Includes information from specialty medical and health assessments and clinical assessments as needed, including, at a minimum, communication, assistive technology, and functional behavior assessments;

(15) Includes information from personal safety assessments pursuant to He-M 1001.06(ab), as applicable;

(16) Includes strategies to address co-occurring severe mental illness or behavioral challenges which are interfering with the individual's functioning, including positive behavior plans or other strategies based on functional behavior or other evaluations or referrals to behavioral health services;

(17) Includes individualized backup plans and strategies;

(18) Provides a method to request updates;

(19) Includes strategies for solving disagreements;

(20) Uses a strengths-based approach to identify the positive attributes of the individual;

(21) Includes the provision of auxiliary aids and services when needed for effective communication, including low literacy materials and interpreters;

(22) Addresses the individual's concerns about current or contemplated guardianship or other legal assignment of rights; and

(23) Explores housing and employment in integrated settings, and develops plans consistent with the individual's goals and preferences.

(e) A copy of the completed plan shall be signed by all persons responsible for its implementation and be provided to the individual and his or her representative.

(f) The service coordinator shall document that he or she has, as applicable, maximized the extent to which an individual participates in and directs his or her person-centered planning process by:

(1) Explaining to the individual the person-centered planning process and providing the information and support necessary to ensure that the individual directs the process to the maximum extent possible within the scope of He-M 522;

(2) Explaining to the individual his or her rights and responsibilities;

(3) Providing the individual with information regarding the services and service providers available;

(4) Eliciting information from the individual regarding his or her personal preferences and service needs, including any health concerns, that shall be a focus of service planning meetings;

(5) Determining with the individual issues to be discussed during all service planning meetings; and

(6) Explaining to the individual the limits of the decision-making authority of the guardian or representative, if applicable, and the individual's right to make all other decisions related to services.

(g) The individual, guardian, or representative may determine the following elements of the service planning process:

(1) The number and length of meetings;

(2) The location, date, and time of meetings;

(3) The meeting participants;

(4) Topics to be discussed; and

(5) Whether any additional assessments or evaluations are needed to assist in the development of the service agreement.

(h) In order to develop or revise a service agreement to the satisfaction of the individual, guardian, or representative, the service planning process shall consist of periodic and ongoing discussions regarding elements identified in He-M 522.08(b) that shall:

(1) Include the individual and other persons involved in his or her life;

(2) Are facilitated by a service coordinator; and

(3) Are focused on the individual's abilities, health, interests, and achievements.

(i) The service planning process shall include a discussion regarding whether or not there is a need for a limited or full guardianship, conservatorship, representative payee for social security benefits, durable power of attorney, durable power of attorney for healthcare, or other less restrictive alternatives to guardianship. The discussion and any recommendations shall be incorporated into the service agreement and the area agency director shall implement any such recommendations.

(j) The service planning process shall include a discussion of the need for assistive technology that could be utilized to support all services and activities identified in the proposed service agreement without regard to the individual's current use of assistive technology.

(k) Service agreements shall be reviewed by the area agency with the individual, guardian, or representative at least once during the first 6 months of service and as needed. The annual review required by He-M 522.09(d)(8) shall include a service planning meeting.

(l) The reviews required in (k) above shall include, at a minimum, the following:

(1) A thorough clinical examination including an annual health assessment;

(2) An assessment of the individual's capacity to make informed decisions; and

(3) Consideration of less restrictive alternatives for service.

(m) The individual, guardian, or representative may request, in writing, a delay in an initial or annual service agreement planning meeting. The area agency shall honor this request.

(n) The service coordinator shall be responsible for monitoring services identified in the service agreement and for assessing individual, guardian, or representative satisfaction at least annually for basic service agreements and quarterly for expanded service agreements.

(o) An area agency director, service coordinator, service provider, individual, guardian, or representative shall have the authority to request a service planning meeting when:

(1) The individual's responses to services indicate the need;

(2) A change to another service is desired;

(3) A personal crisis has developed for the individual; or

(4) A service agreement is not being carried out in accordance with its terms.

(p) At a meeting held pursuant to (o) above, the participants shall document whether and how to modify the service agreement.

(q) Service agreement amendments may be proposed at any time. Any amendment shall be made with the documented consent of the individual, guardian, or representative and the area agency on the "Amendment(s) to Service Agreement" (2015 edition).

(r) If the individual, guardian, representative, or area agency director disapproves of the service agreement, the dispute shall be resolved:

(1) Through informal discussions between the individual, guardian, or representative and service coordinator;

(2) By reconvening a service planning meeting; or

(3) By the individual, guardian, or representative filing an appeal to the department pursuant to He-C 200.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10 (from He-M 522.09); ss by #12683, eff 11-30-18 (formerly He-M 522.11)

He-M 522.11 Service Agreements for Individuals Eligible for Medicaid Home- and Community-based Care Services.

(a) The area agency shall create service agreements for all individuals in accordance with (b)-(j) below.

(b) All service agreements shall:

(1) Be understandable to the individual, guardian, or representative and all service providers responsible for providing services;

(2) At a minimum, be written in plain language and in a manner accessible and understandable to individuals with disabilities and persons who have limited proficiency in english;

(3) Be finalized and agreed to in writing by the individual, guardian, or representative and signed by all providers responsible for the implementation of the service agreement;

(4) Be written such that no unnecessary or inappropriate services or supports will be provided to the individual; and

(5) Be distributed to the individual, guardian, or representative and all providers, including direct support providers, responsible for the implementation or monitoring of the service agreement.

(c) Within 14 days of the initial service agreement meeting pursuant to He-M 522.10(b), the service coordinator shall develop a written basic service agreement, signed by the individual, guardian, or representative and the area agency executive director or designee, that includes the following:

(1) A brief description of the individual's strengths, needs, and interests, as applicable;

(2) The individual's clinical and support needs as identified through current evaluations and assessments;

(3) The specific services to be furnished and the goal associated with each service;

(4) The amount, frequency, duration, and desired outcome of each service;

(5) Timelines for initiation of services;

(6) The provider to furnish the service;

(7) The individual's need for guardianship;

(8) Service documentation requirements sufficient to track outcomes;

(9) Identification of the person or entity responsible for monitoring the plan;

(10) Documentation that the setting the individual resides in was chosen by the individual, guardian, or representative and is integrated in, and supports full access of the individual to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as people not receiving services;

(11) Documentation that the setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting, and that the settings options are identified and based on the individual's needs, and preferences;

(12) Documentation that any restriction on the right of an individual to realize his or her preferences or goals in the services plan is justified by:

a. An identified specific and individualized need that the modification is based on;

b. The positive interventions and supports used prior to any modifications to the individual's rights;

c. The less intrusive methods of meeting the need that were tried but did not work;

d. A clear description of the condition that is directly proportionate to the specific assessed need;

e. The regular collection and review of data to measure the ongoing effectiveness of the modification;

f. Established time limits for periodic reviews of the necessity of the modification;

g. The informed consent of the individual, guardian, or representative;

h. An assurance that the modification will not cause harm to the individual; and

(13) For individuals with a participant directed and managed service arrangement, reporting mechanisms regarding budget updates.

(d) For services provided under He-M 1001, He-M 521, He-M 525, He-M 518, He-M 507, or per individual or guardian request, an expanded service agreement shall be developed pursuant to (e)-(k) below.

(e) The service coordinator shall convene a meeting to prepare an expanded service agreement in accordance with (f)–(k) below within 20 business days of the initiation of services.

(f) If people who provide services to the individual are not selected by the individual to participate in a service planning meeting, the service coordinator shall contact such persons prior to the meeting so that their input can be considered.

(g) Copies of relevant evaluations and reports shall be sent to the individual and guardian at least 5 business days before service planning meetings.

(h) Within 10 business days following a service planning meeting pursuant to (e) above, the service coordinator shall:

(1) Prepare a written expanded service agreement that includes the following:

a. A personal profile;

b. A list of those who participated in the service agreement planning meeting;

c. The information included in the basic service agreement pursuant to He-M 503.10(c);

d. The specific services to be provided;

e. The goals to be addressed, timelines, and methods for achieving them;

f. The persons responsible for implementing each service in the expanded service agreement;

g. Any training needed to carry out the service agreement, beyond the staff training required by He-M 506.05 and other applicable rules, with the type and amount of such training to be determined by the service agreement participants;

h. Services needed but not currently available;

i. Service documentation requirements sufficient to describe progress on goals and the services received;

j. If applicable, reporting mechanisms under self-directed services regarding budget updates and individual and guardian satisfaction with services;

k. If applicable, risk factors and the measures required to be in place to minimize them, including backup plans and strategies; and

l. The individual's need for guardianship, if any.

(2) Contact all persons who have been identified to provide a service to the individual and confirm arrangements for providing such services; and

(3) Explain the service arrangements to the individual and guardian or representative and confirm that they are to the individual's and guardian's or representative's satisfaction.

(i) For individuals who reside in a provider owned or controlled residential setting, the service agreement shall document any modifications of the individual's rights in the residential setting to include:

(1) Privacy in their sleeping or living unit, including doors lockable by the individual with only appropriate staff having keys to doors as needed;

(2) Freedom and support to control their own schedule and activities;

(3) Access to food at any time;

(4) Having visitors of their choosing at any time; and

(5) Freedom to furnish and decorate sleeping or living units.

(j) A provider agency shall only make modifications pursuant to (i) above by documenting in the service agreement the following:

(1) An identified specific and individualized assessed need that the modifications are based on;

(2) The positive interventions and supports used prior to any modifications to the service agreement;

(3) The less intrusive methods used to attempt to meet the need but was unsuccessful;

(4) A clear description of the condition that is directly proportionate to the specific assessed need;

(5) The regular collection and review of data to measure the ongoing effectiveness of the modification;

(6) Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(7) The informed consent of the individual or representative; and

(8) An assurance that the interventions and support will not cause harm to the individual.

(k) Within 5 business days of completion of the service agreement, the area agency shall send the individual, guardian, or representative the following:

(1) A copy of the expanded service agreement signed by the area agency executive director or designee;

(2) The name, address, email, and phone number of the service coordinator or service provider(s) who may be contacted to respond to questions or concerns; and

(3) A description of the procedures for challenging the proposed expanded service agreement pursuant to He-M 522.18 for those situations where the individual, guardian, or representative disapproves of the expanded service agreement.

(l) The individual, guardian, or representative shall have 10 business days from the date of receipt of the expanded service agreement to respond in writing, indicating approval or disapproval of the service agreement. Unless otherwise arranged between the individual, guardian, or representative and the area agency, failure to respond within the time allowed shall constitute approval of the service agreement.

(m) When an expanded service agreement has been approved by the individual, guardian, or representative and area agency director, the services shall be implemented and monitored as follows:

(1) A person responsible for implementing any part of an expanded service agreement, including goals and support services, shall collect and record information about services provided and summarize progress as required by the service agreement or, at a minimum, monthly;

(2) On at least a monthly basis, the service coordinator shall visit or have verbal contact with the individual or persons responsible for implementing an expanded service agreement and document these contacts;

(3) The service coordinator shall visit the individual and contact the guardian, if any, at least quarterly, or more frequently if so specified in the individual's expanded service agreement, to determine and document:

a. Whether services match the interests and needs of the individual;

b. The individual's and guardian's or representative's satisfaction with services; and

c. Progress on the goals in the expanded service agreement; and

(4) If the individual receives services under He-M 1001, He-M 521 or He-M 524, at least 2 of the service coordinator's quarterly visits with the individual shall be in the home where the individual resides.

(n) Service agreements shall be renewed at least annually.

(o) Service agreements shall be reviewed and revised:

(1) When the individual's circumstances or needs change; or

(2) At the request of the individual, guardian, or representative.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10); ss by #12683, eff 11-30-18 (formerly He-M 522.12)

He-M 522.12 Record Requirements for Area Agencies.

(a) Service coordinators or their designees shall maintain a separate record for each individual who receives services and ensure the confidentiality of information pertaining to the individual, including:

(1) Maintaining the confidentiality of any personal data in the records;

(2) Storing and disposing of records in a manner that preserves confidentiality; and

(3) Obtaining a release of information pursuant to He-M 522.04(e) prior to release of any part of a record to a third party.

(b) An individual's record shall include:

(1) Personal and identifying information including the individual's:

a. Name;

b. Address;

c. Date of birth; and

d. Telephone number;

(2) All information used to determine eligibility for services pursuant to He-M 522.05, He-M 522.06, and He-M 522.07;

(3) Information about the individual that would be essential in case of an emergency, including:

a. Name, address, and telephone number of the legal guardian, representative, next of kin, or other person to be notified;

b. Name, addresses, and telephone numbers of current service providers; and

c. Medical information, including:

1. Diagnosis(es);

2. Health history;

3. Allergies;

4. Do not resuscitate (DNR) orders, as appropriate; and

5. Advance directives, as determined by the individual;

(4) A copy of the individual's current service agreement;

(5) Copies of all service agreement amendments;

(6) Progress notes on goals and support services provided as identified in the service agreement;

(7) All service coordination contact notes and quarterly assessments pursuant to He-M 522.11(m)(2)-(4);

(8) Copies of evaluations and reviews by providers and professionals;

(9) Copies of correspondence within the past year with the individual and guardian or representative, service providers, physicians, attorneys, state and federal agencies, family members, and others in the individual's life;

(10) Other correspondence or memoranda concerning any significant events in the individual's life;

(11) Information about transfer or termination of services, as appropriate; and

(12) Proof that the individual was given choice of provider.

(c) All entries made into an individual record shall be legible and dated and have the author identified by name and position.

(d) In addition to the documentation requirements identified in He-M 522, each area agency shall comply with all applicable documentation requirements of other department rules.

(e) Each area agency shall:

(1) Retain records supporting each medicaid bill for a period of not less than 6 years; and

(2) Retain an individual's social history, medical history, evaluations, and any court-related documentation for a period of not less than 6 years after termination of services.

(f) For those receiving medicaid home- and community-based care services, the record shall additionally contain, as applicable, a copy of:

(1) The individual's current service agreement;

(2) All service agreement amendments;

(3) Progress notes on goals and support services provided as identified in the service agreement;

(4) All service coordination contact notes and quarterly assessments pursuant to He-M 522.11(m)(2)-(4); and

(5) Evaluations and reviews by providers and professionals.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18; ss by #12683, eff 11-30-18 (formerly He-M 522.13)

He-M 522.13 Record Requirements for Provider Agencies.

(a) Provider agencies shall maintain a separate record for each individual who receives medicaid home- and community-based care services and ensure the confidentiality of information pertaining to the individual, including:

(1) Maintaining the confidentiality of any personal data in the records;

(2) Storing and disposing of records in a manner that preserves confidentiality; and

(3) Obtaining a release of information pursuant to He-M 522.04(e) prior to release of any part of a record to a third party.

(b) An individual's record shall include:

(1) Personal and identifying information including the individual's:

a. Name;

b. Address;

c. Date of birth; and

d. Telephone number;

(2) Information about the individual that would be essential in case of an emergency, including:

a. Name, address, and telephone number of legal guardian, representative, next of kin, or other person to be notified;

b. Names, addresses, and telephone numbers of current service providers; and

c. Medical information, including:

1. Diagnosis(es);

2. Health history;

3. Current medications;

4. Allergies;

5. Do not resuscitate (DNR) orders, as appropriate; and

6. Advance directives, as determined by the individual;

(3) A copy of the individual's current service agreement;

(4) Copies of all service agreement amendments;

(5) Progress notes on goals and support services provided as identified in the service agreement;

(6) Copies of evaluations and reviews by providers and professionals that are relevant to the individual's current needs;

(7) Copies of correspondence within the past year with the individual and guardian, service providers, physicians, attorneys, state and federal agencies, family members, and others in the individual's life;

(8) Any correspondence involving the individual and the provider agency; and

(9) Information about transfer or termination of services, as appropriate.

(c) All entries made into an individual record shall be legible, dated, and have the author identified by name and position.

(d) In addition to the documentation requirements identified in He-M 522, each provider agency shall comply with all applicable documentation requirements of other department rules.

(e) Each provider agency shall:

(1) Retain records supporting each medicaid bill for a period of not less than 6 years; and

(2) Retain an individual's social history, medical history, evaluations, and any court-related documentation for a period of not less than 6 years after termination of services.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18 (formerly He-M 522.14)

He-M 522.14 Allocation of Funds.

(a) For newly found eligible adults, the period between the time of completion of a basic service agreement and the allocation by the department of the funds needed to carry out the services required by the service agreement shall not exceed 90 days.

(b) For individuals already receiving medicaid home- and community-based care services who experience significant life changes as described in (i) below, the period of time for initiation of new services shall not exceed 90 days from the amendment of the service agreement except by mutual agreement between the area agency and the individual specifying a time limited extension.

(c) Allocation of funds shall be handled by the area agencies and the department through the following processes:

(1) Wait list in compliance with (a) above;

(2) Electronic wait list registry database; and

(3) Advanced crisis funding.

(d) Each area agency shall maintain a wait list for those individuals who need and are ready to receive services currently but for whom funding is not available.

(e) For individuals who are already receiving services, the area agency shall place such individuals' names on the wait list if:

(1) They require a different service; or

(2) Their status has changed.

(f) The area agency shall document its wait list by entering the following information into the electronic wait list registry database at https://nhleads.org:

(1) Name and date of birth of the individual;

(2) The diagnosis that identifies the individual's acquired brain disorder pursuant to He-M 522.02(a);

(3) The individual's category of service, identified as either:

a. Developmental services;

b. Acquired brain disorder services; or

c. In-home support services;

(4) A brief description of the individual's circumstances and the reasons for the request;

(5) The type of services currently received, if any;

(6) An initial cost estimate of the services requested;

(7) The date by which services are needed;

(8) The date the individual's name went on the wait list;

(9) The date on which, and the reasons for which, the individual's name is taken off the wait list; and

(10) The date when the individual began to receive the services for which his or her name had been put on the wait list.

(g) To access the wait list funds appropriated for a given fiscal year, the area agency shall complete the allocation module of the wait list registry by prioritizing each individual's urgency of need based on the following factors:

(1) Advanced age of the family caregiver;

(2) Advanced age of the individual;

(3) Declining health of the family caregiver;

(4) Declining health of the individual;

(5) Sole caregiver with no other supports in the home;

(6) High work demands of the family caregiver;

(7) Family caregiver responsible for others in the family needing care;

(8) Individual with no day services while living with a family caregiver;

(9) Individual's low safety awareness;

(10) Individual's behavioral challenges;

(11) Individual's involvement in the legal system;

(12) Individual living in or at risk of going to an institutional setting;

(13) Individual needing long-term employment funding to maintain his or her job after completing employment training;

(14) Significant regression in individual's overall skills such that the individual's level of independence is diminished; or

(15) Length of time on the wait list as compared to others.

(h) In completing the wait list registry the area agency shall exclude those circumstances where funds might be needed to cover additional expenditures, such as cost-of-living or other wage and compensation increases.

(i) An area agency shall request advanced crisis funding from the department to provide services without delay when there are no generic or area agency resources available and an individual is experiencing a significant life change such that he or she is:

(1) A victim of abuse, neglect, or exploitation pursuant to He-E 700 or He-M 202;

(2) Abandoned and homeless;

(3) Without a caregiver due to death or incapacitation;

(4) At significant risk of physical or psychological harm due to decline in his or her medical or behavioral status;

(5) Presenting a significant risk to community safety; or

(6) In need of long-term employment funding to maintain his or her employment.

(j) To demonstrate the need for advanced crisis funding the area agency shall submit to the department, in writing, a detailed description of the individual's circumstances and needs, a proposed budget, and the assessments and evaluations required by He-M 522.05(a) and He-M 522.10(d).

(k) The department shall review the information submitted by the area agency and approve advanced crisis funding if it determines that one of the conditions cited in (i) above applies to the individual's situation and the individual's name has been entered into the wait list registry.

(l) The department shall utilize funds from statewide individual vacancies in order to finance services that are approved pursuant to (k) above.

(m) For each request an area agency makes for funding individual services, the department shall make the final determination on the cost effectiveness of proposed services.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18 (formerly He-M 522.15)

He-M 522.15 Transfers Across Regions.

(a) If an individual, guardian, or representative plans to relocate where the individual lives and wishes to transfer the individual's area agency affiliation to that region, the individual, guardian, or representative shall notify, in writing, the area agency in the current region and the area agency in the proposed region that the individual is moving and wishes to transfer services to that region.

(b) The current area agency shall send to the proposed area agency all information regarding the individual, including information concerning funding for the individual's services.

(c) The current area agency shall transfer to the proposed area agency all funds being spent for the individual's services, including funds allocated for administrative costs, with the exception of regional family support state funds.

(d) Service coordinators shall coordinate individual transfers so that benefits obtained from third party resources such as medicaid and the division of vocational rehabilitation shall not be lost or delayed during the transition from one region to another.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18 (formerly He-M 522.16)

He-M 522.16 Termination of Services.

(a) If termination of services is being considered by the area agency, individual, guardian, or representative, then the service coordinator shall meet with either the individual or his or her guardian or representative, or both, to discuss the reasons for the recommended termination.

(b) Any recommendation for termination shall be made in writing to the area agency director and be based on at least one of the following:

(1) The individual can function without service(s); or

(2) Services are no longer necessary because they have been replaced by other supports or services.

(c) Within 10 business days of receipt of a recommendation for termination of services, an area agency director shall cause a meeting of the service coordinator, either the individual or his or her guardian or representative, or both, and the service provider(s) to be convened to review the request. The purpose of the meeting shall be to determine if either of the criteria listed in (b) above applies to the individual.

(d) Based on the information presented and determinations made at the meeting, the service coordinator shall prepare a written report for the area agency director which sets forth one of the following:

(1) A statement of concurrence with the recommendation for termination;

(2) A recommendation for continuance; or

(3) Changes to the individual's service agreement.

(e) The area agency director shall make the final decision regarding termination based on the criteria listed in (b) above.

(f) If a decision is made to terminate services pursuant to (e) above, the area agency director shall send a termination notice to the individual, guardian, or representative at least 30 days prior to the proposed termination date. Service may be terminated sooner than 30 days with the consent of the individual, guardian, or representative. The individual, guardian, or representative may appeal the termination decision in accordance with He-C 200.

(g) In each termination notice the area agency shall provide information on the reason for termination, the right to appeal, and the process for appealing the decision, including the names, addresses, and phone numbers of the department and advocacy organizations, such as the disability rights center-NH, which the individual, guardian, or representative may contact for assistance in appealing the decision.

(h) An individual whose services have been terminated may request resumption of services if he or she believes that the reasons for the termination of services no longer apply. Such a request shall be made by the individual, guardian, or representative, in writing, to the area agency director.

(i) Upon request of the individual, guardian, or representative, the area agency director shall resume services to the individual if the criteria in (b) above no longer apply and if funding is available.

Source. #7120, eff 10-20-99; ss by #8974, INTERIM, eff 10-6-07, EXPIRED: 4-3-08

New. #9734, eff 6-25-10; ss by #12683, eff 11-30-18 (formerly He-M 522.17)

He-M 522.17 Voluntary Withdrawal from Services.

(a) An individual, guardian, or representative may withdraw voluntarily from any service(s) at any time, except as provided by RSA 171-B.

(b) The administrator of the service from which withdrawal is made shall notify the area agency in writing of the withdrawal and so indicate in the individual's record when such withdrawal was contrary to the individual's service agreement.

(c) If service staff or a service coordinator for an individual determine that withdrawal from a service might constitute abuse, neglect, or exploitation on the part of a guardian or representative, the staff or service coordinator shall report such abuse, neglect, or exploitation as required by law.

(d) If an individual does not have a guardian or representative and his or her service coordinator or any other person believes that the individual is not making an informed decision to withdraw from services and might suffer harm as a result of abuse, neglect, or exploitation, the area agency shall pursue the least restrictive protective means including, as appropriate, guardianship to address the situation.

(e) An individual who has withdrawn from services may request resumption of services at any time. Such a request shall be made by the individual, guardian, or representative, in writing, to the area agency director.

(f) Upon request of the individual, guardian, or representative, the area agency director shall resume services to the individual if funding is available.

Source. #9734, eff 6-25-10 (from He-M 522.13); ss by #12683, eff 11-30-18(formerly He-M 522.18)

He-M 522.18 Challenges and Appeals.

(a) Any determination, action, or inaction by an area agency may be appealed by an individual, guardian, or representative.

(b) An individual, guardian, or representative may choose to pursue formal or informal resolution to resolve any disagreement with an area agency. If informal resolution is sought, at any time during the process or within 30 business days of the area agency decision, she or he may choose to file a formal appeal pursuant to (e)-(g) below. All formal appeals shall be filed within 30 business days of the area agency determination, action, or inaction.

(c) The following actions shall be subject to the notification requirements of (d) below:

(1) Adverse eligibility actions under He-M 522.05(d) and (l), He-M 522.06(a), and He-M 522.07(b);

(2) Area agency determinations regarding an individual's, guardian's, or representative's selection of provider under He-M 522.08(e) or removal of provider under He-M 522.08(f);

(3) Area agency determinations regarding the removal of an individual, guardian, or representative's selected service coordinator under He-M 522.09(f)(2) and (3); or

(4) A determination to terminate services under He-M 522.16(e).

(d) An area agency shall provide written and verbal notice to the applicant and guardian or representative of the actions specified in (c) above, including:

(1) The specific facts and rules that support, or the federal or state law that requires, the action;

(2) Notice of the individual's right to appeal in accordance with He-C 200 within 30 business days and the process for filing an appeal, including the contact information to initiate the appeal with the department;

(3) Notice of the individual's continued right to services pending appeal, when applicable, pursuant to (g) below;

(4) Notice of the right to have representation with an appeal by:

a. Legal counsel;

b. A relative;

c. A friend; or

d. Another spokesperson;

(5) Notice that neither the area agency nor the bureau is responsible for the cost of representation; and

(6) Notice of organizations with their addresses and phone numbers that might be available to provide pro bono or reduced fee legal assistance and advocacy, including the disability rights center-NH.

(e) Appeals shall be forwarded, in writing, to the bureau administrator in care of the department's office of client and legal services. An exception shall be that appeals may be filed verbally if the individual is unable to convey the appeal in writing.

(f) The bureau administrator shall immediately forward the appeal to the department's administrative appeals unit which shall assign a presiding officer to conduct a hearing or independent review, as provided in He-C 200. The burden shall be as provided by He-C 203.14.

(g) If a hearing is requested, the following actions shall occur:

(1) Current recipients, services, and payments shall be continued as a consequence of an appeal for a hearing until a decision has been made; and

(2) If the department's decision is upheld:

a. Benefits shall cease 60 days from the date of the denial letter or 30 days from the hearing decision, whichever is later; or

b. In the instance of termination of services, services shall cease one year after the initial decision to terminate services or 30 days from the hearing decision, whichever is later.

Source. #9734, eff 6-25-10 (from He-M 522.14); ss by #12683, eff 11-30-18 (formerly He-M 522.19)

He-M 522.19 Waivers.

(a) An applicant, area agency, provider agency, individual, guardian, representative, or provider may request a waiver of specific procedures outlined in He-M 522 by:

(1) Completing and submitting the form titled "NH bureau of developmental services waiver request" (January 2018 edition). The area agency shall submit the request in writing to the bureau administrator; and

(2) If a waiver request is made based on a criminal record, a copy of the current criminal record, dated within a year of when the waiver request is made.

(b) A completed waiver request form shall be signed by:

(1) The individual, guardian, or representative indicating agreement with the request; and

(2) The area agency's executive director or designee recommending approval of the waiver.

(c) A waiver request shall be submitted to:

Department of Health and Human Services
Office of Client and Legal Services
Hugh J. Gallen State Office Park
105 Pleasant Street, Main Building
Concord, NH 03301

(d) No provision or procedure prescribed by statute shall be waived.

(e) The request for a waiver shall be granted by the commissioner within 30 days if the alternative proposed by the requesting entity meets the objective or intent of the rule and it:

(1) Does not negatively impact the health or safety of the individual(s); and

(2) Does not affect the quality of services to individuals.

(f) Upon receipt of approval of a waiver request, the requesting entity's subsequent compliance with the alternative provisions or procedures approved in the waiver shall be considered compliance with the rule for which waiver was sought.

(g) Waivers shall be granted in writing for a specific duration not to exceed 5 years.

(h) Any waiver shall end with the closure of the related program or service.

(i) A requesting entity may request a renewal of a waiver from the department. Such request shall be made at least 90 days prior to the expiration of a current waiver.

Source. #9734, eff 6-25-10 (from He-M 522.15); ss by #12683, eff 11-30-18 (formerly He-M 522.20)