

Family Support 360

FINANCIAL ASSISTANCE GUIDELINES

1. Service Coordinators will pursue all other resources prior to accessing funding available through Family Support. Services provided through Family Support must not be reimbursable under private health insurance, Medicaid State Plan, Medicare part B benefit, or other third-party payers. The Family Support 360 Waiver is the payer of last resort.
2. When services being requested are for a participant under the age of 22, the school district maintains responsibility to provide services or supports that are educationally related when the participant does not have a signed diploma. Companion care, respite care, personal care, and supported employment cannot be delivered during hours that the school district maintains responsibility of.
3. Whenever possible, cost share with other agencies on major expenses such as home modifications and van lifts. The independent living centers are very good resources if the participant's/family's income meets the income guidelines. Additional information on independent living centers can be found at <http://dhs.sd.gov/rehabservices/il.aspx>
4. Make payments to the vendor to avoid out-of-pocket expenses for the participant/family. Maintain supporting documentation for each purchase or transaction (e.g., invoice, receipt, cash register tape, or other supporting documentation that itemizes what was purchased). Waiver funding cannot be paid directly to a participant and/or family member {Note: a parent may be paid utilizing waiver funding if the parent is providing companion care, personal care, or supported employment and has been approved through the agency with choice process}.
5. Be sure that all purchases are specified in the support plan. If an unapproved purchase is made, the Service Coordinator will be responsible for reimbursement to the program budget.
6. If a necessary purchase is not identified in these guidelines/categories, the Service Coordinator may contact the Division of Developmental Disabilities (DDD) for approval prior to purchase.
7. All waiver services must meet the requirements of the Family Support waiver.
8. 100% General Funded waiver services (service coordination, personal care, companion care, SMAES, environmental accessibility adaptive equipment, vehicle modifications, nutritional supplements, and supported employment) are only to be used for non-waiver participants and when vehicle modification services are delivered to repair the participant's vehicle. Waiver participants shall access FSW coded services and any potential budget shortfalls should be addressed through the reallocation of funds within the program budget or through the 799 form process.
9. The following guidelines were developed in accordance with state and federal regulations that define allowable and non-allowable parameters for Medicaid HCBS waivers.

FINANCIAL ASSISTANCE CATEGORIES

3001-G: Child Care – General Funding

Service Coordinators must first refer the family to the Department of Social Services (DSS) Child Care Assistance Program (Phone: 773-4766) and receive a denial for that program and provide evidence of denial to the DDD prior to accessing Family Support. **Family Support will fund only the portion above the market rate for childcare costs for a child thirteen and under without a disability, (i.e., the extra costs because the child has a disability);** within program budget and amounts as agreed upon by family, Coordinator, and the DDD. DSS Child Care Assistance Program rules may be found at <https://dss.sd.gov/docs/childcare/assistance/factsheet.pdf>.

An example of appropriate funding may be if a child care provider would charge \$8 an hour for a child, but due to a participant's additional needs related to their disability that qualifies them for the program would instead charge \$10 an hour, in such an example Family Support funding could be used to cover the \$2 an hour difference.

Non-covered Services:

- Funding cannot be used to cover “typical” childcare costs

3002-G: Counseling/Support Groups – General Funding

Assists the participant/family with the costs of counseling on a sliding fee scale when such costs are not covered by Medicaid or other resources. Department of Social Services, Community Behavioral Health resources (Community Mental Health Centers) or other community services must first be exhausted, and evidence provided to DDD. Fees related to support groups would also be billed under this category.

Non-covered Services:

- Fees for counseling and support groups that are covered by Medicaid, private insurance, or other resources

3003-G: Training/Information– General Funding

Service Coordinators need to refer the participant/family to the Council on Developmental Disabilities prior to accessing Family Support funding for conference registration fees.

Training/Information funding includes but is not limited to:

- Costs associated with conference registration for the participant and one support person
- Costs associated with conference registration for the participant's family member to receive training and information on the participant's disability that qualifies them for Family Support
- Cost of the room(s) and meals at the conference
- Training materials, courses, and publications related to the participant's disability
- Materials that aid in communication (e.g. Sign Language training)

Non-covered Services:

- Funding cannot be used to cover educational items related a participant's IEP goals
- Training and information provided by the service coordinator shall be billed under the “Service Coordination” category

- Transportation costs related to travelling to conferences

3004-G: Housing Assistance – General Funding

Assists the participant/family in a crisis situation. Any housing assistance services must meet the definition of a crisis situation in that the participant is at imminent risk of being homeless or institutionalized, currently residing in an abusive, neglectful, exploitive or life-threatening situation, or where the participant's health, welfare, or safety is in jeopardy due to the family's inability to pay. Family Support Coordinators must explore all possible resources for funding outside of Family Support 360 prior to requesting funding, which could include the possibility of cost-sharing with the family. All requests will be reviewed closely to ensure that all community resources have been exhausted and that funding is not intended to be a long term solution.

Housing Assistance funding includes, but is not limited to, the following if a participant meets the definition of a crisis situation described above:

- Rent
- Security deposit on a rental
- Utility deposit to enable a move
- Utility payments in rare circumstance when the utility will be shut off
- Purchase/repair of a home appliance
- Repair of damage to the participant or family's owned home only if the participant is at a health and safety risk or is unable to access the home
- Necessary safety items in the home identified using the safety checklist (e.g. fire extinguishers, carbon monoxide detectors, smoke detectors, first aid kits for the home) if those items are not available from other resources

Non-covered Services:

- Damage done to the home that does not pose an immediate health and safety risk
- Debts

3005-G: Medical/Dental – General Funding

Assists the participant with emergency medical/dental work and co-payments for prescription medication not covered by another source. Financial assistance may also be provided for over the counter medication needed for a specific medical condition prescribed by a **medical doctor**. Service Coordinators will access all other resources to pay for medication and dental including RX Access (website is <http://www.rxaccess.sd.gov/>), Drug Company Programs, Delta Dental (phone: 224-7345), etc.

Medical/Dental funding includes but is not limited to:

- Emergency medical/dental work that is not covered by Medicaid and is determined to be medically necessary
- Co-payments for a prescription medication not covered by another source

Non-covered Services:

- Does not include over the counter medications or supplies for everyday use (e.g., aspirin, Tylenol, cough syrup, cotton ball, q-tip).
- Medication that is recommended, not prescribed by a licensed physician
- Routine dental work

3006-G: Recreation, Leisure and Social Opportunities – General Funding \$1,000 per plan year

Funding will be provided for the participant (as well as the cost for a sibling or friend to accompany the participant if no other funding is available and it would make a difference in the friend accompanying the participant or not) when the plan demonstrates that recreational opportunities promote inclusion, social relationships with others in the community, and provides a sense of purpose, and contributes to the shaping of who the individual is and how the individual fits into the community.

Recreation funding must be used to increase the participant's opportunity to access their community and interact with other members of the community.

Recreation, leisure, and social opportunity funding includes but is not limited to:

- Cost of summer camp
- Health club/ YMCA class fees or memberships
- Inclusive activity league fees
- Inclusive community activities and events
- May include adaptive recreational equipment

Non-covered Services:

- Individual 1:1 lessons
- Funding cannot be used to purchase recreational items such as kayaks, video games, trampolines, exercise equipment, etc.

3007-G: Transportation – General Funding

Service Coordinators can reimburse for mileage to attend a medical appointment or conference out of their hometown. Coordinators will follow the mileage, hotel, and meal reimbursement rates as prescribed by their fiscal agent.

Recipients must first access Medicaid Nonemergency Medical Transportation (NEMT) (Phone: 773-3656). Family Support funding can only be used to reimburse mileage for travel to medical appointments that are denied by NEMT. Mileage reimbursements provided through the Transportation category encompass any and all costs of ongoing maintenance or repair of vehicles including tire replacement, oil changes, new brakes, etc.

Transportation funding includes but is not limited to:

- Travel, when not covered by NEMT, is from an eligible recipient's city of residence to a medical provider located in another city, between medical providers located in different cities. Mileage is limited to the actual miles between the two cities and does not include miles driven within the city.
- Travel reimbursement not covered by NEMT that is medically necessary as defined in ARSD 67:16:01:06.02 and is not furnished primarily for the convenience of the participant and/or their family
- Public transportation services to medical appointments or to a conference within their hometown
- Public transportation services to promote independence and community integration

Non-covered Services:

- Paying in advance for mileage to medical appointments and conferences
- Reimbursement for gas or mileage cannot be used to travel to recreational activities or community events
- Mileage reimbursement to attend medical appointments covered by NEMT transportation reimbursement
- Reimbursement in excess of what is already covered by NEMT reimbursement
- Transportation to school
- Travel to non medically necessary examinations or treatment

T1016: Service Coordination – Waiver Funding- 15 minute unit at \$18.52/unit

T1016-G: Service Coordination – General Funding- 15 minute unit at \$18.52/unit

Such services which assist participants receiving waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Service Coordinators shall be responsible for monitoring the provisions of services included in the participant's plan at least quarterly.

Service Coordinators shall initiate and oversee the process of assessment and reassessment of the participant's level of care and the review of plans of care. Service Coordination includes assisting the participant/family with accessing resources, developing services and resources, purchasing services, arranging for natural supports and assessments, and monitoring activities.

Service Coordinators assist people with developmental disabilities and their families throughout the self-direction process by providing training and assistance to recruit, interview, hire, and train prospective providers. Service Coordinators can provide resources on the hiring process, including examples on how to write a want ad, examples of appropriate/not appropriate interview questions, etc.

Service Coordinators will refer to the Service Coordination Claim Procedures document for a list of allowable service coordination activities.

Non-covered Services:

- Travel
- Providing a direct support to the participant
- Time spent with the participant or guardian for social reasons or over involvement in family complaints strife instead of referring the family to appropriate resources
- Non-participant specific general filing, meetings, conference calls, emails, correspondence or training.
- Processing requests for payment, purchase orders, vouchers or database entry
- Any other services that do not comply with the most up-to-date financial assistance guidelines
- Time spent compiling information for compliance reviews

T1005 - Respite Care – Waiver Funding - Provider must be age 16. DSS monthly waiver limit is \$2,000.

Short-term services provided to participants who are unable to care for themselves, furnished on a frequency as determined in the plan of care because of the absence or need for relief of those persons who normally provide care. Respite care is not intended to be an ongoing daily service but is meant to provide intermittent, short-term and short-interval breaks for families. Respite Care may be provided in the following locations:

Participant's home or place of residence; foster home; Medicaid certified Hospital; Group home; a home approved in the plan of care which may be a private residence; Licensed Day Care.

The Department of Human Services (DHS) Respite Care Program shall not be utilized when the participant is on the waiver.

Respite care funding includes but is not limited to:

- Providing the level of supervision and care that is necessary to ensure the person's health and safety, this can include services which are related to personal care
- Services which are provided to assist waiver participants who are unable to be left alone due to health and safety concerns

Non-covered Services:

- Respite care shall not be used as day/child care
- Respite is not intended to be provided on a continuous, long-term basis as part of daily services
- Respite care shall not be used to provide services to a participant while the participant is attending school
- Respite care may not be utilized when the parent/caregiver is working

A9900: Specialized Medical and Adaptive Equipment and Supplies (SMAES) – Waiver Funding. DSS monthly waiver limit is \$7,500.

A9900-G: Specialized Medical and Adaptive Equipment and Supplies (SMAES) – General Funding

SMAES includes devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. All items shall meet applicable standards of manufacture, design and installation. In order for an item to be funded under SMAES, it must meet all of the following requirements:

1. Items must be functionally necessary and relate specifically to the participant's medical need or disability that qualifies the individual for the Family Support 360 waiver and be documented in the participant's service plan. SMAES must be based on a reasonable expectation that the item will likely improve the participant's functional abilities or the ability of a caregiver or service provider to maintain the participant in a community setting and delay or prevent institutional placement.
2. Requested purchases within SMAES are to be used for common activities of daily living, the promotion of increased independence with activities of daily living, and assurance of

health and safety within the community. For requests which do not clearly demonstrate compliance with the criteria outlined herein, a Certificate of Medical Necessity (CMN) along with a physician's order must be submitted to for DDD review. The CMN form can be found at:https://dss.sd.gov/formsandpubs/docs/MEDSRVCS/MS-119_CertificateOfMedicalNecessity.pdf

3. Items must provide a direct or remedial benefit to the participant and not otherwise be available through the Medicaid State Plan

Specialized Medical Adaptive Equipment and Supplies includes but is not limited to:

- Modified bicycles or tricycles
- Wheelchair parts and repairs
- Adaptive clothing and specialized shoes
- Communication devices/books recommended by the therapist, school, or doctor
- Bathing lifts/chairs
- Adaptive beds
- Adaptive eating and cooking utensils
- Medication minders
- Sensory equipment (chewies, small indoor trampolines, weighted blankets, platform swings, noise cancelling headphones, sensory chairs)
- Electronic tablet as part of a system of environmental controls and as an augmentative communication device
- Thickening agents
- Specialized Car Seat (For specialized car seats first contact the Department of Social Services, Child Care Services, Child Safety Seat Distribution Program <https://dss.sd.gov/childcare/childsafetyseat/>)

Non-covered Services:

Excluded items include but are not limited to:

- Therapies and therapeutic related items
- Items used for leisure, recreation, education, and vocational purposes only and not determined to be necessary for the member to remain in their home or community;
- Non adaptive items of clothing
- Basic household furniture (e.g. beds for non-medical purposes)
- Non-medical supplies (e.g. cleaning products, routine personal care items)
- Educational items
- Small home appliances
- Televisions, stereos, radios, or DVDS, mp3 players
- Toys (fidget toys, spinners, any other toys)
- Eyeglasses, frames, and lenses
- Recreational or exercise equipment
- Incontinence supplies
- Items which are not of direct medical or remedial benefit to the participant.

Therapist recommendations for SMAES is not required. SMAES equipment paid for by Family Support must have a denial from Medicaid and/or private insurance available prior to waiver funding being requested. The inclusion of a letter of recommendation with the request of an item

is not a guarantee that the item will be approved. All items included in a letter of recommendation must meet the requirements list above.

Repair and/or replacement of equipment may be denied if it is determined there was misuse of the equipment.

S5165: Environmental Accessibility Adaptive Equipment – Waiver Funding. DSS monthly waiver limit is \$10,000.

S5165-G: Environmental Accessibility Adaptive Equipment & Repair – General Funding

Those physical adaptations to the home, owned by the participant or the participant's family, required by the participant's plan of care, which are necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. Service Coordinators will access all other resources, (e.g. Independent Living Centers and/or local service groups as alternate resources) prior to accessing Family Support funding. All services shall be provided in accordance with applicable State or local building codes. Service coordinators shall receive two quotes for any modifications.

Environmental accessibility adaptive equipment funding includes but is not limited to:

- Ramps (portable and permanent)
- Grab-bars
- Widening of doorways
- Bathroom modifications
- Power door openers and door locks
- Wheelchair lifts
- Door sensors and cameras used to support an individual's independence in the home (camera use is restricted to common areas of the home)
- Ceiling track system personnel lifts (Explore portable patient lift options before installing a ceiling track system personal lift. Ceiling track systems should only be used if it significantly increases independence or safety and reduces the need for an attendant.)
- Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant

Non-covered Services:

- Fences
- Adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, home renovation etc.
- Adaptations which add to the total square footage of the home

T2039: Vehicle Modification – Waiver Funding – DSS monthly waiver limit is \$15,000

Vehicle Modifications consist of adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Service coordinators shall receive two quotes for any modifications

Vehicle modification funding includes but is not limited to:

- Conversions including rear, side access and pickup
- Mobility seating
- Wheelchair vehicle lifts

Non-covered Services:

- Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant
- Purchase or lease of a vehicle
- Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of modifications

T2039-G: Vehicle modifications/repair - General Funding

Financial assistance may be provided to assist the participant/family in a crisis situation for emergency vehicle repairs to the primary vehicle used for transportation of the participant to enable the participant and/or family to travel to necessary medical appointments. A crisis situation means the participant is at imminent risk of not receiving necessary medical care (this excludes preventative well-child visits) as a result of maintenance issues involving the primary vehicle used for transportation of the participant and their health is in jeopardy due to the family's inability to pay for the repairs. Request for funding in this category must include documentation of the type and frequency of medical appointments or care that the participant is unable to attend without the repair. Family Support Coordinators must explore all possible resources for funding outside of Family Support prior to requesting funding, which could include the possibility of cost-sharing with the family. All requests will be reviewed closely to prevent a misuse of funding.

Non-covered services:

- Ongoing maintenance and repair of vehicles such as tire replacement, oil changes, heat and a/c systems maintenance, etc.
- Vehicle auto body repairs including any damage due to a collision or weather damage (hail damage, paint chipping)

Note: Mileage reimbursements provided through the Transportation category encompass any and all costs of ongoing maintenance or repair of vehicles including tire replacement, oil changes, etc.

S5125: Personal Care Services – Waiver Funding DSS monthly waiver limit is \$2,500.

S5125-NW: Personal Care Services – General Funding.

Allowable services under this category are to assist the participant in accessing the community or assist the participant in the home with bathing, dressing, personal hygiene, activities of daily living and eating. Personal care providers must meet State standards for this service and may be members of the participant's family, as long as said standards are met.

Personal care services funding includes but is not limited to:

- Assisting the participant in the home with bathing, dressing, personal hygiene, activities of daily living and eating
- Assistance with the preparation of meals, not including the cost of the meals themselves.

- When specified in the plan of care, this service may also include housekeeping chores such as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the participant, rather than the participant's family.

Non-covered Services:

- Payment will not be made for services furnished to a minor by the child's parent or parent's spouse/significant other or to a participant's spouse or significant other.

T1019-ES: Personal Care Services Extended State Plan – Waiver Funding – DSS monthly waiver limit is \$750 for participants over age 21

Personal Care Extended State Plan is a range of assistance provided to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability, including assistance with eating, bathing, personal hygiene, and activities of daily living. This assistance may take the form of hands-on assistance (actually performing a task for a participant) or cuing/prompting the participant to perform a task. Personal Care Extended State Plan is provided as indicated in the approved service plan. Personal Care Extended State Plan services may be provided on an sporadic or on a continuing basis. The amount of Personal Care Extended State Plan service chargeable as a waiver service is the amount incurred after any limits in State Plan service through the Home Health Agency (see below for qualifications) are met.

Personal Care Extended State Plan services provided through the Family Support waiver can enhance the amount, duration, or frequency of State Plan services. Providers qualified to perform Personal Care Extended State Plan services are limited to Home Health Agencies– an organization which is primarily engaged in providing skilled nursing, medical social services, or home health aide services and meets Code of Federal Regulation requirements of a home health provider.

T1020: Companion Services – Waiver Funding DSS monthly waiver limit is \$2,500.

T1020-G: Companion Services – General Funding.

Companion services are non-medical and include supervised integrated socialization, role modeling, and independent living skill development. This may take the form of hands-on assistance or cuing to prompt the participant to perform a task. Companion care is provided in accordance with a goal in the service plan. The coordinator shall assist with the self-directed needs of the participant when recruiting, hiring, and training companion care staff.

Companion care services may include but are not limited to:

- Skill development including such tasks as assistance and/or supervision of meal preparation, laundry and shopping, navigation of public transportation, assistance and/or supervision with acquisition, retention or improvement in self-help, socialization, and adaptive skills

Non-covered Services:

- Payment will not be made for services furnished to a minor by the child's parent or parent's spouse/significant other or to a participant's spouse or significant other.
- Companion care services being used as day/child care during school closures

T2018: Supported Employment – Waiver Funding. DSS monthly Waiver limit is \$750.

T2018-G: Supported Employment – General Funding.

Service Coordinators will refer participants to the Division of Rehabilitation Services (students age 16 and older for Project Skills) prior to accessing Supported Employment Services through Family Support. Supported employment services, which consist of paid employment for participants for whom competitive employment at or above the minimum wage is unlikely, and whom, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants receiving waiver services, including supervision and training. When supported employment services are provided at a worksite in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Supported employment services are directed towards assisting participants to obtain and retain paid employment in community settings. The coordinator shall assist with the self-directed needs of the participant when recruiting, hiring, and training supported employment staff.

Documentation will be maintained in the file of each participant receiving this service that the service is not otherwise available under a program funded by either the Rehabilitation Act of 1973, or the IDEA. {The employment supports are not part of the participant's IEP or the participant has been determined to not meet eligibility or has had a successful closure from Vocational Rehabilitation.}

Supported employment services include but are not limited to:

- Person centered employment planning
- Employment assessment
- Assistive technology assessment
- Travel training
- Community based work experience
- Financial literacy education
- Marketing/Job development
- Soft skills assistance
- Job coaching
- Engagement of natural supports during initial period of employment
- Employer check-in
- Long-term support to help participant maintain integrated employment

Non-covered Services:

- Payment will not be made for services furnished to a minor by the child's parent or parent's spouse/significant other or to a participant's spouse or significant other.
- Transportation will not be provided between the participant's place of residence and the site of the habilitation services or between habilitation sites as a component part of habilitation services. The cost of this transportation is not included in the rate paid to providers of the supported employment.

- Supported employment services do not include production of goods or services, nor compensation for participants.

B4222: Nutritional Supplements – Waiver Funding. DSS monthly Waiver limit is \$1,000

B4222-G: Nutritional Supplements – General Funding

Assistance includes physician prescribed nutritional supplements when they are not available through Medicaid State Plan funding. Nutritional supplements refers to products that are used to complement a participant’s dietary needs (e.g., total parenteral products, enteral products, and meal replacement products). Medicaid State plan pays for *Pediasure* and similar products and needs to be accessed prior to using Family Support. A prescription needs to be maintained in the file and updated yearly.

The Medicaid State Plan covers PKU formula. The purchase of groceries is not an allowable expense as a nutritional supplement.

Nutritional supplements funding includes but is not limited to:

- Boost
- Ensure
- Pediasure

Non-covered services:

- Medications
- Dietary supplements (i.e. vitamins)
- Groceries

3009-G: OTHER – General Funding

The use of the “Other” category should be avoided unless the expense does not fit within any described service code above and there is an urgent need for a participant that is related to the disability that qualifies the individual for Family Support. The other category is not considered a catch all for items that are considered non allowable in another service. Waiver funding cannot be utilized with the “other” code.

The following are items that may go under the “Other” category:

- Advertisement cost for respite care, personal care, or companion care providers;
- Birth certificates needed for Family Support documentation;
- Interpreter/Translation Services;
- GPS tracking system or similar devices when there is a need due to safety issues; and
- Cost of attorney fees for establishing a Guardianship up to \$750.

100: Non-billable Services – Not Funded through Family Support

Includes services provided through natural supports, community organizations, agencies, etc. Services paid for and provided by independent living centers, schools and state agencies, (i.e., Department of Social Services, Division of Rehabilitation Services). Includes equipment, supplies, therapies, etc. that are funded through Medicaid or the local school district.

Items/services not allowable for Family Support Funding (list is not all inclusive):

- Vehicle or trailer purchase
- Incontinence Supplies

- Groceries
- Furniture (unless adaptive in nature)
- Weddings, divorces, or funerals
- Swimming pools and pool accessories
- Playground equipment
- Cable or satellite television services (includes installation and monthly service charges)
- Internet or cell phone services (includes installation and monthly service charges)
- Gift cards
- Cash advances
- State and/or Federal taxes; and
- Excessive funding for recreational activities above the \$1,000 limit

Reimbursement for items that have already been purchased by the participant/family

Reimbursement is not allowed for items purchased by a participant/family that were not prior authorized by the Service Coordinator and the Division via the service plan.

Education related expenses

The participant/family, with the assistance of the Service Coordinator, will work with the school district to assure education related expenses are included in the IEP. The Service Coordinator should offer to advocate for the participant/family in these situations (at the participant/parent's request). Therapies, (e.g., speech, occupational, physical and auditory training) are considered educational expenses and are funded by the school district. Family Support 360 funding cannot be used to provide educational supports to participants that are home schooled.

Waiver services provided to a participant must comply with the DSS monthly waiver limits. Claims that exceed the monthly limit will be denied by the DSS Medical Services.

Appendix A: Provider Qualifications for Services

1. **Personal care 1 (Self-Directed):** The provider will be at least age 18 and older unless there is an occasion when a qualified provider age 18 is not available. On those occasions the provider must be at least 16 years old. Oversight of the provider will be provided by the participant receiving the services or the legal guardian, advocate or family member. Family members who provide personal care services must meet the same standards as providers who are unrelated to the participant. The provider will be able to follow written or verbal instruction given by the participant receiving the service or legal guardian, advocate or family member. The provider must have the ability or skills necessary to meet the participant's needs as delineated in the plan of care. The provider will receive training from the participant or legal guardian, advocate or family member in the performance of all personal care services delineated in the plan of care. The coordinator shall assist with the self-directed needs of the participant when recruiting, hiring, and training personal care staff. The provider will be able to report changes in a participant's condition or needs to the legal guardian, advocate or family member, or Service Coordinator. The provider will maintain confidentiality, and complete required record keeping.

2. **Companion Care:** The provider will be at least age 18 and older unless there is an occasion when a qualified provider age 18 and older is not available. On those occasions the provider must be at least 16 years old. Oversight of the provider will be provided by the participant receiving the service or the legal guardian, advocate or family member. The provider will be of good health, have the ability to read, write and follow instructions. The provider will be able to report changes in a participant's condition or needs to the legal guardian, advocate or family member, or Service Coordinator. The provider will maintain confidentiality, and complete required record keeping. The provider will have the ability or skills necessary to meet the participant's needs as delineated in the plan of care. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

3. **Supported Employment:** The provider will be at least 18 years of age unless there is an occasion when a qualified provider at least 18 years of age is not available. On those occasions the provider must be at least 16 years old. Oversight of the provider will be provided by the participant receiving the service or the legal guardian, advocate or family member. The provider will be able to follow written or verbal instructions given by the participant, the legal guardian, advocate or family member. The provider will maintain confidentiality, and complete required record keeping. The provider will have the ability or skills necessary to meet the participant's needs as delineated in the plan of care. The provider will receive training from the participant or legal guardian, advocate or family member in the performance of all supported employment services delineated in the plan of care.

4. **Respite Care:** The provider will be at least 16 years of age. Oversight of the provider will be provided by the participant receiving the service or the legal guardian, advocate or family member. The provider will be able to follow written or verbal instructions given by the participant, the legal guardian, advocate or family member. The provider will maintain confidentiality, and complete required record keeping. The provider will have the ability or skills necessary to meet the participant's needs as delineated in the plan of care. The provider will receive training from the participant or legal guardian, advocate or family member in the performance of all supported employment services delineated in the plan of care.