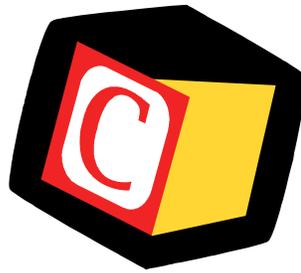


Attachment F
Children's Creative Connection (C3)
Working Guidelines
June 2008

Children's Personal Care Services
Children's Creative Connection
(C³)
Working Guidelines



STATE OF VERMONT
DEPARTMENT OF DISABILITIES, AGING AND
INDEPENDENT LIVING

Division of Disability and Aging Services
June 2008

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TABLE OF CONTENTS

What is Children's Creative Connection (C ³)?	1
How Do I Know If C ³ Is Right For Us?	2
How Is the Budget Calculated?	3
What Is a Support Broker and How Do I Find One?	4
What is a Support Broker?	4
How Do I Choose a Support Broker?	5
What If I Want to Change My Support Broker?	5
How Do I Know I Don't Need a Support Broker Anymore?	5
How Do I Develop My Child's Spending Plan?	7
Developing an Initial Spending Plan	7
Changing a Spending Plan	7
What Is Allowed Through C ³ ?	9
Personal Care Payroll	9
Non-payroll Items	10
Services	10
Allowable Specialized Therapies and Services	11
Goods	12
Allowable Goods	12
What Is NOT Allowed Through C ³ ?	13
Personal Care Payroll—what is not allowed	13
Non-payroll Items—what is not allowed	14
Services	14
Goods	15
Excluded Goods and Services	15
Other Important Points of the C ³ Option	16
Transition Into and Out of the C ³ Option	16
Reassessments and Extensions	17
Access to Services Across Six-month Periods	17
What Are Our Appeal Rights?	18
What is Medicaid Fraud?	18
Is My Child's Information Confidential?	19
Who Do We Call with Questions?	19

Appendices

DAIL Background Check Policy

Appeal Rights

What is Children's Creative Connection (C³)?

Children's Creative Connection (C³) is an option within Children's Personal Care Services. For an individual to qualify for C³, s/he must first be determined eligible for **Children's Personal Care Services**. It is important to remember that Children's Personal Care Services is a Medicaid service; a child must *have* and *retain* active Medicaid enrollment to be able to access services through the C³ option of Children's Personal Care Services.

The goal of the Children's Creative Connection is to provide increased flexibility and access to services through Children's Personal Care Services. This option will allow for a family, guardian or individual¹ to pay a different wage, access specialized therapies, purchase non-reimbursable Medicaid goods and services or do such things as make minor modifications to their home.

Once eligibility for Children's Personal Care has been determined, a family may pursue the C³ option. This option allows a family to convert the recipient's allocation of Children's Personal Care Services hours into a budget, and with the help of a **Support Broker**, develop a detailed **spending plan**, including personal care, services, and goods which relate to the needs identified in the annual Children's Personal Care Services assessment or goals set out in the Children's Personal Care annual care plan. This spending plan must be approved by both the support broker and centrally by Children's Personal Care Services staff, in the Division of Disability and Aging Services at DAIL.

ARIS Solutions remains involved as the payroll agent; families are not directly given the funds to manage. Families are, however, given more control over what services are provided to help their child more effectively develop personal care skills.

¹ For simplicity of language, the term "family" will be used throughout these guidelines, since families tend to apply for services and direct them on behalf of the individual. This is not to discount others serving as guardian, home/shared living provider or self-directing services.

How Do I Know If C³ Is Right For Us?

This option isn't the right choice for everyone. It is important to understand that the Children's Creative Connection isn't more; it's different.

This option is not about changing the intent of Children's Personal Care Services. C³ is still about identifying the above average care-giving needs that a child has based on their diagnosis or disability—compared to typical age peers (the *medical necessity* of the child) and assigning a number of hours per week for care. The difference is that C³ takes the number of hours per week and converts it into to a budget that the family can access with greater flexibility.

If a child's care needs have not changed, choosing this option will not result in a higher allocation (i.e., more money). Instead, it allows for increased flexibility. This is the key difference between C³ and traditional Children's Personal Care Services.

The purchase of Support Broker services is required as part of the spending plan. A family must meet with the Support Broker initially to develop a budget and spending plan, have a check-in with them at least once within the six-month period, and develop the next budget and spending plan. At reassessment time, the Support Broker will work with the family to ensure that the child's assessment is completed and submitted on time. The family will be required to purchase at least three hours of Support Broker services in each six-month period. Families may demonstrate a level of competency with budget and spending plan development and management of service, such that it may be no longer necessary to purchase Support Broker services after 18 months.

Under C³, the family is responsible for budgeting for **employer taxes**. Previously, employer taxes were not something that the family factored in, because under traditional Children's Personal Care families budget *hours, not dollars* and taxes were invisible in the budgeting process, but still being paid.

In C³, the family is now responsible for the dollar value of the child's services, and therefore must also now consider the employer taxes when building the payroll portion of their spending plan.

ARIS Solutions will help make sure that families know what tax rates to pay for each wage.

C³ is more work to manage than traditional Children's Personal Care Services; it is more involved than simply submitting timesheets every other week. Families can choose to purchase the services of a service coordinator/case manager to help them with this responsibility, but families should understand that it may be more work than what they are previously accustomed to.

These are some of the trade-offs that families must be willing to make for increased flexibility and access to other services.

How Is the Budget Calculated?

A budget is based on the number of hours a child has been allocated by her/his assessment. To calculate the total dollar value of the allocation, of the number of hours are multiplied by \$10 for every hour the child has in their plan.

Budgets are allocated in six-month blocks, just as hours of care are in traditional Children's Personal Care Services. If a child is authorized 15 hours per week, or 390 hours for a 6 month period, the total budget for the spending plan would be \$3,900 (390 by \$10). This may seem like a lot of money, but it must last six months.

After calculating the budget, the Support Broker works with the family to develop a spending plan, within the six-month allocation which may include personal care payroll, services, and goods, to ensure that the child gets the care needed over the course of the six months.

The Support Broker will also work with the family to help ensure that they understand the details of the program, so that the spending plan is easily approved and the family can begin accessing the C³ option quickly.

What Is a Support Broker and How Do I Find One?

What is a Support Broker?

A Support Broker is someone who will help calculate the child's budget, once a family has chosen the C³ option. After having calculated the child's budget, the Support Broker will help develop a spending plan. This spending plan is based on needs identified in the child's assessment and care plan to access goods and services throughout the six-month allocation period.

The Support Broker will check-in with the family periodically during the child's authorization period and help develop the next spending plan. If needed, the Support Broker may be assist with scheduling, or perform, the child's annual reassessment.

The role of the Support Broker is to help the family understand the guidelines, what the family is allowed to purchase through this option, what is affordable given the child's budget and help the family meet the timeframes for reassessment and submission of paperwork, to both ARIS and Children's Personal Care Services.

Initially, it is a requirement to purchase the services of a Support Broker. Over time, a family may demonstrate the ability to calculate a budget, develop an approved spending plan, and submit a reassessment within the pre-determined time-frames, this requirement may be waived at the discretion of the Children's Personal Care Services Program. All C³ participants must purchase Support Broker Services for at least 18 months (or three consecutive allocation periods).

A Support Broker is different than a **case manager/service coordinator**. While a Support Broker may have some ideas about where a family can find employees or know of an excellent local resource, the primary role of a Support Broker is to develop spending plan and assist the family with completing enrollment paperwork. A Support Broker is not expected to

provide the larger function of a case manager/service coordinator or to help find workers.

Families may, if they choose, purchase case management/service coordination. This, however, is a separate service.

How Do I Choose a Support Broker?

Choice of a Support Broker depends on where the family lives and what services the child currently receives. When a family transitions into the C³ option, they are given a list of who provides Support Broker services in that region.

In some regions, the local mental health, home health or developmental services agency may provide this service. If a family is already working with someone from one of these agencies, a family might want to see if that individual can serve as the Support Broker since s/he already knows the child.

Vermont Family Network is helping as a state-wide network resource for identifying Independent Support Brokers.

To select a Support Broker, simply contact the individual of choice directly. Please note that a family cannot start work on developing the child's spending plan until the beginning of a 6-month allocation period.

What If I Want to Change My Support Broker?

A family may change Support Brokers, if alternatives are available in their region. Either the family or the new Support Broker must contact the old Support Broker and the Children's Personal Care staff, in writing, so they will know the change has been made.

How Do I Know I Don't Need a Support Broker Anymore?

After 18 months, or three budget cycles on the program, a family can ask to have the Support Broker requirement waived, if the family feels that a Support Broker is no longer needed to help develop and manage the budget and spending plan. The process starts when the family contacts the CPCS staff stating that they no longer need a Support Broker. The C³ staff will

then check to see if the family had experienced any budget problems in the previous 18 months (for example, running out of money, trying to purchase non-allowed items, or having difficulty managing payroll.) They may also talk to the current support broker and other people working with the family and the child. Children's Personal Care Services staff, based on information from the family, ARIS Solutions and the current Support Broker, make the determination.

If after no longer using a Support Broker, a family begins to experience problems with their spending plan, managing their budget or submitting payroll forms, it may be determined that Support Broker services are, again, needed. Children's Personal Care Services staff, with information from ARIS Solutions, reserves the right to make that determination.

How Do I Develop My Child's Spending Plan?

Developing an Initial Spending Plan

The Support Broker helps to develop the initial spending plan for each 6-month allocation period. The first time a family opts into C³, the spending plan is developed at the beginning of the period, but, if the family chooses to stay in the C3 option, all other plans must be developed—and approved—before the next period starts, with the help of the Support Broker.

The Support Plan must be developed based services to address the personal care needs of the child. These care needs must have been indicated in the most recent assessment forwarded to Children's Personal Care Services.

Changing a Spending Plan

Spending plans can be changed within the 6-month allocation period. All changes to a spending plan must be approved by the Support Broker, and must relate to an identified personal care need.

A spending plan cannot be changed more than two times within a 6-month period.

Who Helps Me with My Payroll and Purchases?

Intermediary Service Organization (ISO)

Payroll services are managed by ARIS Solutions, just like in the traditional program. They will receive a copy of the spending plan and will only pay up to the amount budgeted in each category.

Some important things to remember:

- Since families can set workers' wages, each employee's hourly wage must be put on each timesheet and family's must budget for the appropriate employer taxes.
- ARIS will send a report after each payroll to tell how much has been spent and how much remains. It is the family's responsibility

to read the report and track available funds. This report shows only what *has actually been spent*. If employees have worked but not submitted their timesheets, for example, that expense will *not* show up on the report.

Other Purchases

One of the benefits of the C³ option is the budget can be used to purchase other items besides personal care. (What can and can't be bought is in the next section.)

All purchases must be included in the spending plan that a family works out with their Support Broker and be pre-approved.

When a family wants to make a planned purchase, they will use the "Non-payroll expense sheet" that ARIS sends to the family when they start the program. The family should fill that form out and attach a receipt or invoice/bill for the item(s) to the sheet and submit it to ARIS. ARIS will then either reimburse the family or write a check to the provider. ARIS will not reimburse for items that are not pre-approved on the spending plan.

What Is Allowed Through C³?

C³ allows for two major categories of purchases in a spending plan to address the above average care needs of an individual: personal care payroll and non-payroll goods and services.

Personal Care Payroll

Personal care is the direct, hands-on care provided to the individual.

All workers must be 18 years of age, unless a variance has been approved by the Children's Personal Care Services program, and are subject to the **Department of Disabilities, Aging and Independent Living's background check policy.**

Changing the Wage

In the C³ program, families can increase or decrease the wages beyond the traditional Children's Personal Care Services rate of \$10/hr. Families may set individual wages for workers, as long as wages are at least Vermont minimum wage.

Please remember under the C³ option, families are responsible for budgeting for and paying employer taxes.

Daily Rate

It is possible to negotiate a daily rate for personal care services, which includes overnight care. This daily rate cannot not exceed \$160/day and cannot be less than a rate that when calculated, equates to paying Federal minimum wage (contact ARIS Solutions for the current minimum daily rate). Paying a daily rate for care still requires paying employer taxes.

Paying Mileage

Families may reimburse for mileage related to activities, when taking the child into the community. Additionally, families may (but are not required) to pay the mileage to and from work for employees. Mileage

reimbursement cannot exceed the State of Vermont mileage reimbursement rate. (www.per.state.vt.us/index.php?page=26)

Families may choose to pay a mileage stipend instead of paying per mile.

➤ Multiple Employees

Families may pay more than one employee to provide care for the individual at the same time.

Non-payroll Items

Non-payroll items are goods and services which directly relate to the care and well-being of the child. In order for a good or service to be approved, it must be clearly indicated on the annual Children's Personal Care assessment or an articulated goal in the Children's Personal Care annual care plan.

Allowable goods and services are limited to those not otherwise covered by Medicaid.

It is important to note that while a good or service may be allowable, it may not be indicated in every child's assessment and care plan, and therefore, may not be approved for every recipient's spending plan.

Services

➤ Rates

Service costs must not exceed the typically charged rates for specialized therapies and services by the provider.

➤ Training

Costs for conferences, trainings, classes, etc., related to the child's special care needs, for employees and parents, are allowable.

Employees' time attending a conference or training is paid as a payroll costs.

➤ Accommodations/Lodging and Travel Expenses

The C³ program will pay for travel expenses (e.g., accommodations/lodging and/or other expenses incurred related to travel) for employees only. This includes travel expenses for conferences, trainings and vacations that are directly related to the child.

The C³ program will not pay travel expenses for parents or the child.

🚧 Advertising

Costs associated with advertising for workers are allowable.

🚧 Specialized Therapies and Services

Allowable services include specialized therapies that are not covered by Medicaid or private insurance (e.g., supplemental physical or occupational therapy such as therapeutic horseback riding, enhanced therapies such as psychotherapy from a non-Medicaid provider, disability-specific therapy not covered by Medicaid such as Relationship Development Intervention therapy).

When choosing to access supplemental therapies, a family must access, and exhaust, all available services through State Plan Medicaid.

Providers must be licensed/certified, in fields that the State provides licensing/certification, and must be prepared to show proof, if requested.

Other services may be allowed through this option. These services must be therapeutic in nature. Services that are not normally considered therapeutic but have been adapted to the needs of the child may be acceptable if the adapted or therapeutic nature of the activity is clearly documented,

Allowable Specialized Therapies and Services include, but are not limited to:

- Case Management/Service Coordination
- Psychotherapy, by a non-Medicaid provider
- Supplement therapies over and above those approved by Medicaid (such as physical and occupational therapy)
- Therapeutic horseback riding
- Adaptive swimming lessons

Adaptive yoga
Therapeutic camp programs
Behavior therapist and consultant services
Nutritionist services

Goods

Goods are tangible items purchased to support the child's identified needs. They may not relate to the needs of the family. Since the intent of the Children's Personal Care Services Program is to address the above average personal care needs, it is not expected that family will use this program to purchase a significant amount of goods.

➤ Maximum Amount

The maximum amount that can be used for goods, in a 6 month period, is \$500.00.

➤ Partial Payments

Goods funding can be used to pay part of a larger, *allowable*, purchase; e.g., \$500 paid towards \$1,500 of an item that has been approved in the child's spending plan.

Allowable Goods include, but are not limited to:

- Sensory equipment, e.g., indoor swing, weighted vest, etc.
- Medically related supplies not covered by Medicaid, such as hand sanitizer, lotion, etc.
- Specific brands of diapers or briefs not covered by Medicaid for older children or more diapers/briefs than Medicaid has authorized in a time period
- Fitness club memberships
- Supplies for home modifications (i.e., lumber for a ramp)

What Is NOT Allowed Through C³?

While the C³ option provides increased flexibility for families and recipients, this program has limitations.

Personal Care Payroll—what is not allowed

➤ Other Children in the Family

The C³ option is intended to provide care to the child for whom it is authorized, not to other children in the family. Therefore C³ does not pay for a situation where the employee provides care to siblings, while the parent provides 1:1, therapeutic care to the authorized child.

➤ Paying Parents

C³ does not provide an option to pay parents to provide any services (direct care, support brokerage, case management/service coordination, therapy, etc) for their own children.

Additionally, the Federal government prohibits the paying of biological, adoptive, and step-parents to minor children. The Department of Disabilities, Aging and Independent Living extends this prohibition to include parental domestic (live-in boy/girlfriend) and Civil Union partners, developmental home/shared living providers, foster parents, guardians, parents of adult children and all persons serving as the child's primary care giver. The C³ program does *not* change these restrictions.

➤ Paying Mileage for Parents

Mileage reimbursements, or other travel expenses, to parents, for activities related to the child, are not allowable expenses. It is expected parents will transport their child(ren) and therefore these expenses are not covered through this program.

Medicaid may reimburse families for some transportation costs related to medical appointments. For more information, contact the Office of Vermont Health Access at 800.250.8427 or the local public transportation provider (www.vtpa.net).

Non-payroll Items—what is not allowed

Services

➤ Institutionalizations

Vermont has a long standing commitment to keeping children in the community with families, in the least restrictive environments. C³ cannot be used to support an institutional placement, including a short-term placement at a nursing facility for respite purposes.

➤ Child Care and Afterschool Programs

All children need child care and afterschool activities; the option cannot be used towards tuition at daycare or towards group afterschool activities.

C³, like traditional Children's Personal Care Services, can be used to provide an individualized attendant in these settings to increase the child's success.

The State of Vermont offers a child care subsidy; for more information about who qualifies and how to apply, contact the Department for Children and Families at 802.241.3110.

➤ School Services

The C³ option cannot be used for services specified as needed in a child's Individual Education Plan (IEP) or educational services.

➤ Services Not Related to the Child or the Child's Disability

The C³ option must be used to support the child in a therapeutic way; these services must be directly related to needs identified in the assessment and care plan. Services included in the spending plan cannot be for the family as a whole or non-therapeutic for the child.

Examples:

- The spending plan *cannot* include car repairs, even though a well-maintained car may increase a family's ability to care for the child. This is a typical family expense.

- Haircuts for the child authorized for the C³ option *cannot* be included in a spending plan, although it is individualized services. Haircuts are not therapeutic services and do not help the child gain self-care skills. Additionally, all children, regardless of disability, need haircuts.

✚ Travel Expenses for Parents

C³ will not pay for travel expenses incurred by the family related to travel for the child or family. This includes transportation, accommodations/lodging for conferences, vacations, errands directly related to the child's personal care and training for parents or the child.

✚ Aversive Practices

C³ funds cannot be used for **aversive practices**, including restraint and restrictive procedures.

DAIL has adopted guidelines for positive behavior support. Please call 802.241.2614 for a copy of these guidelines.

Goods

Allowable goods are items that relate directly to needs identified in the assessment and care plan. Goods must primarily support the authorized child, not the family as a whole.

✚ Items Related to Typical Needs

Families cannot purchase common household items not related to the child's disability or health condition.

Excluded Goods and Services include, but are not limited to:

- Rent/mortgage
- Heating fuel
- Household appliances (e.g., washing machine, dryer, vacuum cleaners, etc)
- Pets, pet food, veterinary bills, etc, excluding for therapy and services animals
- Groceries and meals
- Clothing

- Day Care and afterschool programs
- Non-therapeutic camp
- Diapers for children under the age of three
- Briefs ("pull-ups") for children under the age of five
- Sports equipment
- Books, reading materials

It is important to understand the limitations of this program; if a family repeatedly demonstrates inability to manage this option—as defined by two or more significant founded concerns reported to, or observed by, Children's Personal Care Services staff within a six-month period—may result in removal from this option.

Founded concerns include, but are not limited to:

- overuse of funds
- mismanagement of services
- failure to submit payroll and non-payroll expense forms within pre-determined timeframes
- abuse, neglect, exploitation
- failure to submit reassessment by due date, and
- suspected fraud

Recipients would return to traditional Children's Personal Care Services to access services.

Additionally, misuse of the C³ program, just as misuse of Children's Personal Care Services, could be considered **Medicaid Fraud**, which is a federal offense and carries serious penalties.

Other Important Points of the C³ Option

Transition Into and Out of the C³ Option

Families must wait until the beginning of a six-month allocation to begin accessing the C³ option. A family must start the C³ option at the beginning of a new pay period, so it may be necessary to extend Traditional CPCS services for up to two weeks to ensure there is no gap in services for the child.

Once in the C³ option, if a family determines that it is not working for them, they must wait until the end of the six-month period to return to traditional Children's Personal Care Services. Meanwhile, the family can choose to develop a new spending plan as "Personal Care Payroll" and pay \$10 per hour to closely approximate traditional Children's Personal Care Services.

Reassessments and Extensions

To remain active in the C³ option, individuals *must submit* their annual Children's Personal Care Services reassessment to Children's Personal Care Services staff *20 days prior* to the end date of services for review and approval. Children's Personal Care Services staff can *not* provide extensions for the C³ option. Failure to submit reassessments in a timely manner will result in removal from the C³ option and placement back in traditional Children's Personal Care Services.

Access to Services Across Six-month Periods

Families enrolled in the C³ option will *not* be able to access additional funds by "borrowing" against future six-month allocations, under any circumstances. Families may be personally responsible for wages, services provided and/or goods ordered, if there are not funds available through the C³ option of Children's Personal Care Services. It is important to pay careful attention to the reports that ARIS sends after every pay period and manage the budget.

As with traditional Children's Personal Care, funds not spent within the authorization period do not carry over into the next six-month period for use.

What Are Our Appeal Rights?

A family has appeal rights on any decision that they feel unfavorably affects access to services for their child.

Detailed appeal rights are included in written notifications sent to families (and attached to this document in the appendices).

Please refer to the appeal right document for specific information timeframes and instructions on accessing appeal rights.

What is Medicaid Fraud?

Medicaid fraud is a federal offense. Medicaid fraud can be committed by the family or employee. It includes providing incorrect information about a disability/health condition to get services, overstating level of need to increase the level of services authorized and filing claims for services not provided in any service paid for by Medicaid.

Misuse of C³, either inadvertent or intentional, can be considered Medicaid fraud and may be investigated by the Medicaid Fraud and Residential Abuse Unit, Office of the Attorney General.

Medicaid fraud is serious; the penalties may include incarceration and fines. Additionally if a parent is convicted of Medicaid fraud, s/he will no longer be able to manage their child's services. In cases where the Medicaid Fraud Unit is investigating, it may be strongly suggested that **administrative action** be taken by DAIL. Administrative action may include employees from the Children's Personal Care Services program looking into the issue to determine what happened and how best to proceed, given the information gathered.

Some of the consequences of Medicaid Fraud, administrative action, and misuse of the Children's Personal Care and the C³ option include, but are not limited to, the family no longer having access to the C³ option, no longer

being allowed to family manage the services, and no longer having access to the flexibility inherent in the program. DAIL reserves the right to make these decisions. Children's Personal Care Services is an entitlement services, however the C³ option is not.

To report suspected fraud, contact the Medicaid Fraud Unit at 802.241.4440. The report will be investigated by specially trained individuals. While it might be uncomfortable to report something questionable that is observed, it is the responsibility of individuals accepting Medicaid services and funds.

Is My Child's Information Confidential?

State and Federal laws require that information be kept confidential. There are provisions that allow for the minimum amount of information necessary to be shared between providers, for treatment purposes, and the payroll agent, for service provision.

Who Do We Call with Questions?

For questions or issues regarding policy or concern with the payroll agent or your support broker, contact the Children's Personal Care Services program at 888.268.4860.

For question or issues regarding Medicaid or Medicaid enrollment, contact the Office of Vermont Health Access through Maximus—the customer service agent—at 800.250.8427.

For questions or to report any issues regarding Medicaid fraud, contact the Medicaid Fraud and Residential Abuse Unit at 802.241.4440.

For questions or issue regarding family managed payroll or to request additional timesheets or enrollment forms, contact ARIS at 800.798.1658.

For concerns about child abuse or neglect, call your local Department of Children and Families - Family Services Division.

BACKGROUND CHECK POLICY**Effective: April 1, 2006****I. Introduction**

Performing background checks on individuals who work with vulnerable people is a component of preventing abuse, neglect and exploitation. This policy describes when a background check is required, what the components of a background check are and what is done if a background check reveals a potential problem.

Background checks supplement but do not replace reference checks. Background checks should never be relied upon as a substitute for personal contact with former employers or others who are in a position to have personal knowledge about the worker's qualifications to work with vulnerable people.

II. Definitions

A. **"Background check"** includes all of the following:

1. A request for information about all substantiated findings of abuse, neglect, and exploitation directed to the Department for Children and Families (DCF) child abuse registry;
2. A request for information about all substantiated findings of abuse, neglect, and exploitation directed to the Department of Disabilities, Aging and Independent Living (DAIL), Division of Licensing and Protection adult abuse registry;
3. A request for information about all criminal convictions directed to the Vermont Crime Information Center (VCIC);
4. An on-line search of the Exclusions Database of the federal Department of Health and Human Services' Office of Inspector General as www.oig.hhs.gov.
5. For volunteers or workers who will be paid to transport a person by motor vehicle, a complete Motor Vehicle Driver Record from the Vermont Department of Motor Vehicles.

B. **"Person who receives services"** means an individual who receives support and/or services through a program administered by the Department of Disabilities, Aging and Independent Living (DAIL), including, but not limited to personal services, community supports, adult day services, housing and home supports, case management, service planning and coordination, respite care, companion care, clinical or other mental health services; crisis services, supported employment services, transportation, nutrition, nursing, and other kinds of care for which a worker receives reimbursement. Specific services include, but are not limited to:

- Adult Day Services
- Attendant Services

- Children's Personal Care Services
- Choices for Care Waiver Services (home-based, nursing facility and enhanced residential care)
- Developmental Disability Services
- High Tech Services
- Homemaker Services
- Traumatic Brain Injury Waiver Services

The term includes individuals who self-, family- or surrogate-manage their services. The term does *not* include individuals who receive supports through the Flexible Family Funding program, the Dementia Respite Program, the National Family Caregiver Support Program, or Flex Funds.

- C. **“Agency or provider”** means an organization that operates programs/services administered by DAIL for any “person who receives services.”
- D. **“Worker”** means an individual who volunteers (including those paid a stipend or expense reimbursement) and an individual who is employed or contracted by an agency/provider (including contracted home providers, shared living providers, developmental home providers, foster care providers), surrogate, family member or person who receives services.

III. Requirements for Background Checks

- A. Background checks are **required** for all workers who are paid with funds administered by DAIL and who:
1. Provide care to a person who receives services; or,
 2. Manage funds or services on behalf of a person who receives services.
- B. Background checks are **required** for any volunteers recruited and placed by an agency or provider who will work alone with a person who receives services.
- C. Background checks are **recommended** for respite workers hired by families through the Flexible Family Funding program, the Dementia Respite Program, the National Family Caregiver Support Program (NFCSP) or Flex Funds. Families may use an Intermediary Service Organization (ISO) to complete the background check for a nominal fee. Providers and agencies are required to notify families of this option.
- D. In addition to meeting the requirements of this policy, facilities or agencies that are state licensed and/or federally certified must follow abuse prevention protocols as specified in applicable state and federal regulations.

IV. Responsibility for Ensuring that Background Checks Are Completed

- A. Any agency or provider employing a worker or supervising a volunteer is responsible for ensuring that the required background checks are completed, or for arranging for the required checks to be completed by an Intermediary Service Organization (ISO).

- B. An Intermediary Services Organization (ISO) is responsible for ensuring that the required background checks are conducted for any workers who will be paid through the ISO. In addition to the required background checks, the ISO shall conduct any recommended background checks requested by an employer/contractor.
- C. Employers and contractors who will be paying workers through the ISO are responsible for obtaining the signed and completed forms necessary for the background checks to be completed.

V. Payment for Background Checks

Applicants for employment shall not be charged for the costs of background checks. The costs of background checks are considered part of the administrative costs for an agency or provider, and are part of the contract for services of an ISO.

VI. Employment Pending Completion of Background Checks

- A. An offer of employment or contract may be made contingent upon a satisfactory background check.
- B. A worker, contractor or volunteer may, at the discretion of the employer or contracting entity, provide services to a person pending receipt of the results of the background check, but under no circumstances may a worker or contractor be paid for longer than sixty (60) days without receipt of a completed background check.

VII. Periodic Updating of Background Checks

Subsequent to the initial background check, an agency or provider shall have a policy for conducting periodic random checks of workers and volunteers covered above.

VIII. Restriction Upon Paying Persons with a History of Substantiated Abuse, Neglect, or Exploitation, or History of Certain Crimes

Funds administered by DAAIL may not be used to employ, place or contract with a person who has:

- A. A substantiated record of abuse, neglect, or exploitation of a child or a vulnerable adult;
- B. Been excluded from participation in Medicaid or Medicare services, programs, or facilities by the federal Department of Health and Human Services' Office of the Inspector General; and/or,
- C. A criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving violation of a position of trust, including, but not limited to:

Aggravated assault	Hate motivated crime
Aggravated stalking	Kidnapping
Aggravated sexual assault	Lewd and lascivious conduct
Assault and robbery	Simple assault
Manslaughter	Sexual assault
Assault upon law enforcement	Murder

Cruelty to children	Domestic assault
Arson	Stalking
Extortion	Embezzlement
Abuse, neglect, or exploitation of a vulnerable adult or child	Recklessly endangering another person while driving

IX. Questionable Background Check Results

If a background check reveals a non-restricted conviction or motor vehicle violation, the employer may at his/her discretion hire or contract with the worker.

X. Variations

Variations of this policy may be granted only under exceptional circumstances. The agency or provider employing or contracting with a worker or supervising a volunteer is responsible for the decision to grant a variance under this policy. For individuals who are employed or contracted by a home provider (e.g., developmental home, shared living, foster care) surrogate, family member or person who receives services, a request for variance, including a copy of the information under question, must be made in writing to:

Deputy Commissioner
Division of Disability and Aging Services
Department of Disabilities, Aging and Independent Living
Weeks Building, 103 South Main Street
Waterbury, VT 05671-1601

The following factors must be considered in the decision to grant or deny any variance:

- A. Age of the individual at the time of the crime or substantiation;
- B. Nature and seriousness of the crime (e.g., were there circumstantial reasons; was it related to a specific relationship, etc.);
- C. The person's involvement with the criminal justice system and/or child or adult abuse, neglect or exploitation systems since the occurrence;
- D. The amount of time that has passed since the substantiation or conviction;
- E. Willingness of the individual to pursue expungement of any child or adult abuse substantiation;
- F. Disclosure to the person receiving services, their surrogate, and legal guardian (if there is one).

Written documentation of the decision to grant a waiver must be made stating the rationale and any conditions.

This information is important. If you do not understand it, take it to your local office for help.

Ces informations sont importantes. Si vous ne les comprenez pas, apportez-les à votre bureau local pour recevoir de l'aide.

Это важная информация. Если она Вам непонятна, возьмите это письмо и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Esta información es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Maelezo ya barua hii ni muhimu. Kama huielewi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi.

Thông tin này rất quan trọng. Nếu quý vị không hiểu nội dung trong đó, hãy đem thư này đến văn phòng tại địa phương của quý vị để được giúp đỡ.

Your Right to Appeal

If you disagree with a decision about your benefits, you may request an appeal and/or a fair hearing. **You must make this request within 90 days of the date of the decision.** The date of the decision is the date on the Notice of Decision that you received indicating your authorized level of service

- An appeal is a review of the decision by someone else within the Department of Disabilities, Aging and Independent Living.
- A Fair Hearing before the Human Services Board is a legal proceeding where an attorney representing the state and you and/or your representative will present information to an impartial hearing officer.

You and/or your representative have the right to be at both the appeal and the fair hearing.

Appeals are usually decided within 45 days. If you need more time to get ready for your appeal, the time can be extended another 14 days. **If the decision you want to appeal reduces or eliminates a service that you have been getting, you can ask that the service stay at its current level while your appeal is being decided. You must ask to have your benefits continued within 10 days of the date of the original decision.**

To appeal, write to the Commissioner's Office, 103 South Main Street, Waterbury, VT 05671-1601 or call 888-268-4860. To request a fair hearing from the Human Services Board, write the Human Services Board, 120 State Street, Montpelier, VT 05620-4301.

We will assist in you filing an appeal or a request for a fair hearing.

