APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: ALABAMA

B. Waiver Title(s):

AL Home and Community -Based Waiver for the Elderly and Disabled (EDW)
AL Alabama Community Transition (ACT)
AL State of Alabama Independent Living (SAIL)
AL Technology Assisted Waiver (TA)

C. Control Number(s):

EDW 0068.R07.03
ACT 0878.R01.02
SAIL 0241.R05.01
TA 0407.R03.01

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: Start Date: January 27, 2020
Anticipated End Date: January 26, 2021

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___ Services

i.__X_ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. _X__Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

EDW and ACT:

- Temporarily expand eligibility for home-delivered meals to waiver participants of all ages.
- Temporarily provide for two-weeks' worth of meals in certain situations where an individual has food insufficiencies due to the COVID-19 virus, on condition that this does not exceed 2 meals per day for a maximum of 14 meals per week

ACT, SAIL, TA:
Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Specialized Medical Supplies authorized in an individual's care plan as of the date of the COVID 19 PHE, including adult protective undergarments, catheter bags and other supplies covered under that service; and for nonprescription Assistive Technology authorized in an individual's care plan as of the date of the COVID-19 PHE. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d._X__ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.__X_ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

Temporarily allow initial training for new employees to be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods. This applies to the following services and provider types:
Adult Day Health: Director, Adult Day Care Worker (EDW, ACT)
Homemaker: Homemaker, Homemaker Supervisor (EDW); Home Care Agency Workers (ACT)
Adult Companion: Companion Service Worker (EDW, ACT)
Personal Care: Personal Care Worker, LPN (EDW, ACT, SAIL, TA)
Personal Assistance Services: Home Health Agency Worker (SAIL)
Unskilled Respite: Respite Care Worker, Unskilled (EDW, ACT, SAIL)
Home-Delivered Meals: Delivery Driver (EDW, ACT).

For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

ii._X__ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

ACT, SAIL, TA:
Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Specialized Medical Supplies and Assistive Technology items from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f._x__ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

EDW, ACT:
For Personal Care, Homemaker, and Respite services, temporarily increase DSP rates by 10% to cover additional staffing requirements and infection control/PPE supplies due to COVID-19. Temporarily increase Case Management by 5.5% to cover additional staffing requirements and infection control/PPE supplies due to COVID-19. The rate development otherwise remains the same. These rate increases will be in effect beginning on June 1, 2020, and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.

Service	Base Rate	New Rate
Homemaker	$3.75	$4.13
Personal Care	$3.83	$4.21
Unskilled Respite	$3.83	$4.21
Skilled Respite	$7.11	$7.82
Case Management Monthly	$271.48	$286.48

SAIL: For Specialized Medical Supplies, temporarily increase the monthly rate from $150 to $175 to cover cost increases due to supply shortages. These rate increases will be in effect beginning on June 1, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.

g. X Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.
[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

EDW, ACT, SAIL, TA:
The state will ensure the person-centered service plan is modified to allow for additional supports/and or services to respond to the COVID-19 pandemic. The specificity of such services including amount, duration and scope will be appended as soon as possible but no later than 30 days to ensure that the specific service is delineated accordingly to the date it began to be received. In the event a PCCP and/or Plan of Care cannot be developed in time to obtain the required signatures through the mail or other means (e.g., HIPAA-compliant electronic methods) before their effective dates, the Support Coordinator may document verbal approval of the services on the part of the person/guardian and verbal agreement from the provider to deliver the services to substitute until the signatures can be obtained. The use of e-signatures that meets privacy and security requirements will be added as a method for the participant or legal guardian signing the PCCP to indicate approval of the plan. Services may start while waiting for the signature to be returned to the case manager, whether electronically or by mail. Signatures will include a date reflecting the PCCP meeting date. An electronic or written signature is required within 45 days of the change(s) made to the PCCP.

h._X__ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

EDW, ACT, SAIL, TA:
Providers must submit incident reports for participants who test positive for COVID-19 within 48 hours of receiving notification and disclose any exposure of the COVID-19-positive participant to any other waiver participants and/or staff persons. Incident reports must also be submitted within 48 hours for each other participant potentially exposed. While incident reports are required in these instances, there is no automatic requirement for an investigation or corrective action plan, unless the Medicaid Agency or Operating Agency specifically directs that either/both be completed.

i._ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

j._X__ Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

EDW, ACT: In response to the defined emergency, and in order to maintain a viable workforce, the state may elect to make retainer payments to waiver providers. The State confirms that retainer payments are for direct care providers who normally provide services that include habilitation that includes a component of personal care and personal care, but are currently unable to due to complications experienced during the COVID-19 pandemic because the waiver participant is sick due to COVID-19; or the waiver participant is sequestered and/or quarantined based on local, state, federal and/or medical requirements/orders. The state will implement a distinguishable process to monitor payments to avoid duplication of billing. The habilitation (Adult Day Health) and personal assistance retainer will begin on March 13, 2020, and the time limit may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bed-hold" in nursing facilities.

k.___ Temporarily institute or expand opportunities for self-direction.
[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. **HCBS Regulations**
   a. ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic. (ACT, SAIL)

2. **Services**
   a. ☒ Add an electronic method of service delivery (e.g., telephonic) allowing services to continue to be provided remotely in the home setting for:
      i. ☒ Case management (EDW, ACT, SAIL)
      ii. ☒ Personal care services that only require verbal cueing (EDW, ACT, SAIL, TA)
      iii. ☐ In-home habilitation
      iv. ☒ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers). (EDW, ACT, SAIL, TA)
      v. ☐ Other *[Describe]:*

   b. ☒ Add home-delivered meals
   c. ☒ Add medical supplies, equipment and appliances (over and above that which is in the state plan) (ACT, SAIL, TA)
   d. ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case**

management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.
b. ☐ Additional safeguards listed below will apply to these entities.

4. **Provider Qualifications**
   a. ☐ Allow spouses and parents of minor children to provide personal care services
   b. ☐ Allow a family member to be paid to render services to an individual.
   c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*
   d. ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. **Processes**
   a. ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date. (EDW, ACT, SAIL, TA)
   b. ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings. (EDW, ACT, SAIL, TA)
   c. ☒ Adjust prior approval/authorization elements approved in waiver. (EDW, ACT, SAIL, TA)
   d. ☒ Adjust assessment requirements (EDW, ACT, SAIL, TA)
   e. ☒ Add an electronic method of signing off on required documents such as the person-centered service plan. (EDW, ACT, SAIL, TA)

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Ginger
Last Name	Wettingfeld
Title:	Director, LTC Healthcare Reform
Agency:	Alabama Medicaid Agency
Address 1:	501 Dexter Ave
Address 2:	PO Box 5624
City	Montgomery
State	AL
Zip Code	36104
Telephone:	334-242-5018
E-mail	Ginger.wettingfeld@medicaid.alabama.gov
Fax Number	334-353-4182

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	NA
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: **Date: 6/3/2020**

_____/S/_____
State Medicaid Director or Designee

First Name: *Stephanie*
Last Name *Azar*
Title: Commissioner
Agency: Alabama Medicaid Agency
Address 1: 501 Dexter Ave
Address 2: PO Box 5624
City Montgomery
State AL
Zip Code 36104
Telephone: 334-242-5600
E-mail Stephanie.azar@medicaid.alabama.gov
Fax Number 334-242-5097

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Adult Day Health (EDW)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Adult Day Health (ADH) is a service that provides Elderly and Disabled Waiver (EDW) clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis. Transportation between the individuals place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service. Adult Day Health is not an entitlement. It is based on the needs of the individual client.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The unit of service will be a client day of Adult Day Health Service consisting of four (4) or more hours at the center. The four (4) hour minimum for a client day does not include transportation time, lunch breaks or free time. The number of units authorized per visit must be stipulated on the PCCP and the Service Authorization Form.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Director of Center			
	Registered Nurse or Licensed Practical Nurse			
	Adult Day Care Worker			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Director of Center			High School Diploma or equivalent, TB skin test annually. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic.
Registered Nurse or Licensed Practical Nurse	Licensed by the Alabama Board of Nursing		Preferably with 2 years of experience as a registered nurse or licensed practical nurse in public health, hospital or long-term care nursing, testing, prevention, and control of TB annually. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic

Adult Day Care Worker	Alabama Driver's License		Have a valid Al. Driver's license if transporting ADH clients,; possess a valid picture identification; all workers must have a 6 hour in service training per calendar year and submit to a program for testing, prevention and control of TB annually The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Director of Center	Alabama Dept. of Senior Services	Verified as Necessary For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Registered Nurse or Licensed Practical Nurse	Alabama Dept. of Senior Services	Verified as initially and annually thereafter. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.
Adult Day Care Worker	Alabama Dept. of Senior Services	Verified as Necessary For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Case Management (EDW)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Case Management is an activity which assists individuals in gaining access to appropriate, needed, and desired waiver and other State Plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. Case Management Services may be used to locate, coordinate, and monitor necessary and appropriate services. Case Managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individuals Person Centered Care Plan. Case Management is a waiver service available to all Elderly and Disabled (E/D) Waiver client's Case Management activities can also be used to assist in the transition of an individual from institutional settings, such as hospital, and nursing facilities into community settings. The case manager will assist in the coordination of services that help maintain an individual in the community. Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The unit of service will be fifteen minutes (15) beginning on the date that the client is determined eligible for E/D Waiver Services. Case Management Service provided prior to waiver approval should be considered administrative. At least one face to face visit is required monthly in addition to any other Case Management activities. The following temporary modification applies: All face to face visits will be waived and visits will occur by telephone or video conference. There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. During this period it is required that the case manager make at least 3 face-to-face visits and have monthly contact with the individual or sponsor. For Transitional CM a unit of service that assists individuals transitioning from institutional settings into the community will be fifteen (15) minutes beginning on the first date the case manager goes to the institution to complete an initial assessment. If Transitional CM is provided it should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the E&D Waiver, reimbursement will be at the administrative rate. In instances in which services are offered by a relative, the State will ensure that there is no conflict of interest by prohibiting the relative who is the direct service provider from participating in the PCCP development and signing the service authorization log if the recipient is unable to do so. The Case Manager will monitor these instances to ensure that the relative who is the direct service provider is providing the waiver services according to the PCCP. Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:		Agency. List the types of agencies:
	Bachelor of Arts or Bachelor of Science Degree			
	RN			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Bachelor of Arts or Bachelor of Science Degree			Preferably in a human services-related field from an accredited college or university
Registered Nurse	Alabama Board of Nursing		Must be current

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Bachelor of Arts or Bachelor of Science Degree	Alabama Dept. of Senior Services	Initially. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.
Registered Nurse	Alabama Dept. of Senior Services	Verified initially and annually. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification					
Service Title:	Companion (EDW)				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Definition (Scope)**:**					
Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion Service is provided in accordance with a therapeutic goal as stated in the Person-Centered Care Plan, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client. Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the Plan of Care.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
The unit of service will be fifteen (15) minutes of direct Companion Service provided to the client. The number of units per visit must be indicated on the PCCP and the Service Authorization Form. The amount of time authorized does not include the Companion Workers' transportation time to or from the client's home, or the Companion Worker's break or mealtime. A unit of service will be 15 minutes of direct Companion Service provided to the client.					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Companion Worker			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Companion Worker			Complete a probationary period determined by the employer with continued employment contingent on completion of the initial training/orientation training program. All Companion Workers must have at least six (6) hours in-service training per calendar year; and submit to a program for the testing, prevention, and control of tuberculosis annually. The following temporary modifications apply: The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic. The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Companion Worker	Alabama Dept. of Senior Services	Verified initially and bi-annually thereafter The following temporary modifications apply: For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Home Delivered Meals (EDW)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

Home Delivered Meals are provided to an eligible waiver participant who is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the participant can be addressed by the provision of home-delivered meals. When specified in the Person-Centered Care Plan, this service may include seven (7) or fourteen (14) frozen meals per week. ~~In addition, the service may include the provision of two (2) or more shelf-stable meals to meet emergency nutritional needs when authorized on the participant's Plan of Care.~~ During times of the year when the state is at an increased risk of disaster from either hurricanes, tornados or ice/snow conditions, the Meals Coordinator will coordinate with the vendor to implement a Disaster Meal Services Plan. The following temporary modification applies: Temporarily provide for two-weeks' worth of meals in certain situations where an individual has food insufficiencies due to the COVID-19 virus, on condition that this does not exceed 2 meals per day for a maximum of 14 meals per week. Temporarily expand eligibility for home-delivered meals to waiver participants of all ages.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home Delivered Meals are not an entitlement. Provision is based on the needs of the individual, and the unit(s) of service needed will be specified in the PCCP. The unit of service is one (1) package of seven meals. For shelf-stable meals, the unit of service is two (2) meals, packaged as individual meals and delivered to the participant's residence.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:
		Driver of delivery truck		
		Registered Dietician		

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Driver of delivery truck	Valid driver's license	None	Should receive initial and on-going training in the proper service, handling, and delivery of food. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training.
Registered Dietician	State of Alabama valid state license	Current dietician registration	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Driver of delivery truck	Alabama Dept. of Senior Services	Verified initially and monitored on an on-going basis. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.
Registered Dietician	Alabama Dept. of Senior Services	Verified initially and annually. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification					
Service Title:	Homemaker (EDW)				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Definition (Scope)**:**					
Homemaker Service provides assistance with general household activities such as meal preparation and routine house cleaning and tasks, such as changing bed linens, doing laundry, dusting vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. The service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, and writing and mailing. Homemaker Services is not an entitlement. It is based on the needs of individual client as reflected in the PCCP.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
The unit of service will be fifteen (15) minutes of direct Homemaker Service provided in the client's residence (except when shopping, laundry services, etc. must be done off-site). The number of units and services provided to each client is dependent upon the individual clients needs as set forth in the PCCP. The amount of time authorized does not include the Homemakers transportation time to or from the client's residence, or the Homemaker's break or mealtime.					
Provider Specifications					
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:	
	Homemaker				
	Homemaker Supervisor				
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian	
Provider Qualifications (*provide the following information for each type of provider)*:					
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*		

Homemaker			Be able to read and write; a valid picture ID; complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker initial training/orientation program. This training must be completed prior to providing services and at least six (6) hours completed per calendar year. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods. The workers must get a tuberculin skin test annually. The following temporary modifications apply: The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic.
Homemaker Supervisor			Be able to read and write; a valid picture ID; complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker initial training/orientation program. This training must be completed prior to providing services and at least six (6) hours completed per calendar year. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods. The workers must get a tuberculin skin test annually. The following temporary modification applies: The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Homemaker	Alabama Dept. of Senior Services	Verified initially and bi-annually thereafter. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.
Homemaker Supervisor	Alabama Dept. of Senior Services	Verified initially and bi-annually thereafter. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Personal Care (EDW)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

Personal Care services provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the clients family. Personal Care Services is not an entitlement. It is based on the needs of individual client as reflected in the PCCP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The unit of service will be fifteen (15) minutes of direct PC Service provided in the client's residence. The number of units and services provided to each client is dependent upon the individual clients needs as set forth in the client's plan of care. The amount of time authorized does not include the Personal Care Workers transportation time to or from the client's residence, or the worker break or mealtime.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:
		Personal Care Worker		
		Registered Nurse or Licensed Practical Nurse		

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Care Worker			Employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies approved by the Commissioner of the Medicaid Agency. The Personal Care Worker is required to receive initial training/orientation before providing services. A minimum of twelve (12) hours of relevant in-service training per calendar year is also required. The following temporary modifications apply: The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic. The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods.

Registered Nurse or Licensed Practical Nurse	Current license from the State of Alabama.		Employed by a Medicare/Medicaid Certified Home Health Agency or other health care agencies approved by the Commissioner of the Medicaid Agency. The Personal Care Worker is required to receive initial training/orientation before providing services. A minimum of twelve (12) hours of relevant in-service training per calendar year is also required. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Care Worker	Alabama Dept. of Senior Services	Verified initially and bi-annually thereafter. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Registered Nurse or Licensed Practical Nurse	Alabama Dept. of Senior Services	Verified initially and bi-annually thereafter. The following temporary modifications apply: For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Respite-Skilled (EDW)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care. Skilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household. Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The unit of service is fifteen (15) minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Workers (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the clients PCCP established by the Case Manager.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Licensed Practical Nurse- LPN (skilled respite)			
	Registered Nurse -RN (Skilled Respite)			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Practical Nurse- LPN (skilled respite)	State of Alabama Nursing License		This service will be performed by a Licensed Practical Nurse with an active license from the Alabama State Board of Nursing and preferably with at least two (2) years' experience as a LPN in public health, hospital, home health, or long term care nursing and submit to a program for the testing, prevention, and control of tuberculosis annually. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic. The LPN must work under the supervision of an RN.

Registered Nurse - RN (Skilled Respite)	State of Alabama Nursing License		This service will be performed by a Registered Nurse (RN) with an active license from the Alabama State Board of Nursing and preferably with at least two (2) years' experience as a RN in public health, hospital, home health, or long term care nursing and submit to a program for the testing, prevention, and control of tuberculosis annually. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse -RN (Skilled Respite)	Alabama Dept. Of Senior Services	Verified initially and annually thereafter. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Licensed Practical Nurse- LPN (skilled respite)	Alabama Dept. Of Senior Services	Verified initially and annually thereafter For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Respite-unskilled (EDW)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care. Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household. Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the PCCP.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The unit of service is fifteen (15) minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Workers (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the clients PCCP established by the Case Manager.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Respite Care Worker- Unskilled			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Respite Care Worker- Unskilled			This service will be performed by non-licensed personnel who possess the ability to read and write, as well as the ability to work independently on an established schedule and can follow the plan of care with minimal supervision. Unskilled Respite Workers must meet the same orientation and in-service requirements as a Personal Care Worker and submit to a program for testing, prevention and control of tuberculosis. The following temporary modifications apply: The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic. The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Respite Care Worker-Unskilled	Al. Dept. of Senior Services	Verified initially and bi-annually thereafter For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Personal Care (ACT)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:** ACT Waiver Personal Care Services provide assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the waiver participant, rather than the participant's family. Personal care providers must meet State standards for this service. Personal care must be provided by an individual that is qualified and employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service: The Unit of Service will be per 15-minute increments of direct PC service provided. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Provider Contract. (Except for 1915j participants, under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child, to a recipient's spouse, or to a minor by a parent or stepparent.)	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Home Care Agency or Home Health Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Care Agency or Home Health Agency	Business	Certificate of Need (CON) if the provider type is a Home Health Agency	Waiver of CON approved by Medicaid Commissioner

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Home Care Agency or Home Health Agency	Operating Agency Certification Surveyor	Annually upon initial approval by AMA and biannually thereafter if no compliance concerns exist, For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Specification	
Service Title:	Case Management (ACT)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:** Case Management (CM) Services assist individuals who receive waiver services in gaining access to needed and desired waiver and other State Plan services, as well as needed medical, social, educational and other appropriate services, regardless of the funding source for the services to which access is gained. CM services may be used to locate, coordinate, and monitor necessary and appropriate services. CM activities will be used to assist in the transition of an individual from institutional settings into community settings. The CM will assist in the coordination of services that help maintain an individual in the community. CM activities may also serve to provide necessary coordination with providers of non-medical and non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which the person may be eligible. CM are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the participant's Plan of Care. CM is a waiver service available to all ACT Waiver clients. CM assist clients to make decisions regarding long term care services and supports. CM ensures continued access to waiver and non-waiver services that are appropriate, available and desired by the participant. Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers on a Fee for Service basis based on actual units provided and the rate on file.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service: The amount, frequency or duration of this service is dependent upon the participant needs as set forth in the Plan of Care for waiver case management. The unit of service will be per 15-minute increments commencing on the date that the participant is determined eligible for ACT Waiver services and entered into the Medicaid Long Term Care (LTC) file. Case Management service provided prior to waiver approval should be considered transitional. There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. The CM should have regular contact with the individual or sponsor throughout the transition period. The following temporary modification applies: all services may be provided remotely through an electronic method (e.g., telephonic). If CM is provided it should not be billed until the first day the participant is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate. Alabama's 1915b PCCM-E (ICN) will receive a monthly capitated payment inclusive of HCBS Case Management. The ICN will review the Case Management claims and reimburse the HCBS Case Management providers on a Fee for Service basis based on actual units provided and the rate on file.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Governmental Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Governmental Agency	Professionals having earned a Bachelor's degree or a Master's degree, from an accredited college or university, or having earned a degree from an accredited School of Nursing.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Governmental Agency	OA staff is responsible for verifying date of expiration of license of the case management staff.	Verification of provider qualifications is monitored annually. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Home Delivered Meals (ACT)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:** Home Delivered Meals are provided to an eligible waiver participant who is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the participant can be addressed by the provision of home-delivered meals. When specified in the Plan of Care, this service may include seven (7) or fourteen (14) frozen meals per week. During times of the year when the state is at an increased risk of disaster from either hurricanes, tornados or ice/snow conditions, the Meals Coordinator will coordinate with the vendor to implement a Disaster Meal Services Plan. The following temporary modification applies: Temporarily provide for two-weeks' worth of meals in certain situations where an individual has food insufficiencies due to the COVID-19 virus, on condition that this does not exceed 2 meals per day for a maximum of 14 meals per week. Temporarily expand eligibility for home-delivered meals to waiver participants of all ages	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Home Delivered Meals are not an entitlement. Provision is based on the needs of the individual, and the unit(s) of service needed will be specified in the Plan of Care. The unit of service is one (1) package of seven meals. For shelf-stable meals, the unit of service is two (2) meals, packaged as individual meals and delivered to the participant's residence.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Driver of Delivery Truck
				Registered Dietician
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Driver of Delivery Truck	Valid driver's license		Should receive initial and on-going training in the proper service, handling, and delivery of food. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods.
Registered Dietician	State of Alabama license		Current dietician registration

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Driver of Delivery Truck	Operating Agency	Verified initially and monitored on an on-going basis. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends.
Registered Dietician	Operating Agency	Verified initially and monitored on an on-going basis. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Medical Supplies (ACT)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:** Medical supplies are in the Plan of Care, and enable waiver participants to increase their ability to perform activities of daily living, to maintain health and safety in the home environment. All waiver medical supplies must be prescribed by a physician, and be specified in the Plan of Care. Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Specialized Medical Supplies authorized in an individual's care plan as of the date of the COVID 19 PHE, including adult protective undergarments, catheter bags and other supplies covered under that service. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K. Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency. The case manager must provide the participant with a choice of vendors in the local area of convenience. Description of Services to Be Provided 1. Medicaid will pay for a service when the service is covered under the ACT Waiver and is physician prescribed. "The service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each participant must substantiate the need for services, and must detail all treatment provided. 2. Medical supplies are necessary to maintain the participant's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization. 3. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-Tips, etc. 4. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant. 5. All items shall meet applicable standards of manufacture, design and installation. Supplies are limited to $1800.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipients	
Specify applicable (if any) limits on the amount, frequency, or duration of this service: All waiver medical supplies must be prescribed by a physician, and be specified in the Plan of Care. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Medical Supplies are limited to $1800.00 per recipient per year. The OA must maintain documentation of items purchased for recipient.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Certified Waiver Provider			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Waiver Provider	Business		Providers of this service will be those who have signed provider agreements with the Alabama Medicaid Agency, and the OA. The case manager must provide the participant with a choice of vendors in the local area of convenience. Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Specialized Medical Supplies from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Waiver Provider	Operating Agency	Prior to contract approval, annually or bi-annually for approved providers based on previous score, or more often if needed based on service monitoring concerns. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable). For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Adult Day Health (ACT)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:** Adult Day Health (ADH) is a service that provides ACT Waiver participants with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis. Transportation between the participant's place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service. Adult Day Health is provided based on the needs of the individual client.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service: The unit of service will be a participant day of Adult Day Health Service consisting of four or more hours at the center. The four hour minimum for a participant day does not include transportation time, lunch breaks or free time. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Director of Center
				Adult Day Care Worker
				Registered Nurse or Licensed Practical Nurse

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Director of Center			Have a high school diploma or equivalent. Tested for tuberculosis annually. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic.

Adult Day Care Worker	Alabama Driver's License		Have a valid Alabama driver's license if transporting Adult Day Health clients; possess a valid, picture identification. All Adult Day Health Workers must have at least six (6) hours in-service training per calendar year and submit to a program for the testing, prevention, and control of tuberculosis annually. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic.
Registered Nurse or Licensed Practical Nurse	Licensed by the Alabama Board of Nursing		Two (2) years' experience as a Registered Nurse or Licensed Practical Nurse preferred. Must submit to a program for the testing, prevention, and control of tuberculosis annually. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Director of Center	Operating Agency Alabama Medicaid Agency	Verified annually or bi-annually based on provider history. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Adult Day Care Worker	Operating Agency Alabama Medicaid Agency	Verified annually or bi-annually based on provider history. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.
Registered Nurse or Licensed Practical Nurse	Operating Agency Alabama Medicaid Agency	Verified annually or bi-annually based on provider history. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Homemaker (ACT)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:** Homemaker Service provides assistance with general household activities such as meal preparation and routine house cleaning and tasks, such as changing bed linens, doing laundry, dusting vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. The service may also include assistance with such activities as obtaining groceries and prescription medications, and writing and mailing items. Homemaker service will only be provided for the waiver participant and will not extend to other individuals in the household. Homemaker Services authorized based on the needs of individual participant as reflected in the Plan of Care.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service: The unit of service will be 15 minutes of direct Homemaker Service provided in the participant's residence (except when shopping, laundry services, etc. must be done off site). The number of units and services provided to each client is dependent upon the individual waiver participant's needs as set forth in the Plan of Care. The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Home Care Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Home Care Agency	Business		Workers must be able to read and write, possess a valid picture ID, complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker initial training/orientation program. This training must be completed prior to providing services and at least six (6) hours completed per calendar year. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods. The workers must participate in a program for the prevention and control of tuberculosis annually. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Care Agency	Operating Agency Alabama Medicaid Agency	Verified initially and bi-annually thereafter. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Adult Companion Service (ACT)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:** Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the participant with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the waiver participant. Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to participant safety and/or toward promoting participant independence or toward promoting the mental or emotional health of the client. Companion Service is provided based on the needs of the individual waiver participant as reflected in the Plan of Care.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service: The unit of service will be 15 minutes of direct Companion Service provided to the participant. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include the Companion Worker's transportation time to or from the participant's home, or the Companion Worker's break or mealtime. A unit of service will be 15 minutes of direct Companion Service provided to the participant.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Companion Service Worker

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Companion Service Worker			Complete a probationary period determined by the employer with continued employment contingent on completion of the initial training/orientation training program. Initial training and orientation must be completed prior to a worker being authorized to provide services. All Companion Workers must have at least six (6) hours in-service training per calendar year; and submit to a program for the testing, prevention, and control of tuberculosis annually. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods. The initial and annual TB testing will be performed as a screening assessment during the time of the pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Companion Service Worker	Operating Agency	Verified initially and bi-annually thereafter. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Assistive Technology (ACT)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:** Assistive Technology includes devices, pieces of equipment or products that are modified, customized and used
to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisitions, selection, design, fitting, customizing, adaptation, application, etc. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant. This service is necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the ACT Waiver. All items shall meet applicable standards of manufacture, design and installation.

Description of Services to Be Provided:

1. The ACT Waiver program will pay for equipment when it is not covered under the regular State Plan and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records on each participant must substantiate the need of services, must include all findings and information supporting medical necessity, and must detail all treatment provided. Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation (NET) Services have been exhausted or is not feasible.
2. Assistive Technology includes pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities individuals with disabilities.
3. The amount for this service is $15,000.00 per waiver recipient per lifetime. Any expenditure in excess of $15,000.00 must be approved by the ACT Coordinator and the designated Medicaid Agency personnel.
4. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver.

Assistive Technology must be ordered by the physician. It must be documented in the Plan of Care and case narrative. The case manager must have the prescription for Assistive Technology.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: The amount for this service is $15,000.00 per waiver participant. Any expenditure in excess of $15,000 (per participant per lifetime) must be approved by the ACT Coordinator and the designated Medicaid Agency personnel.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Vendor with a Business License			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Vendor with a Business License	Business		Vendor is responsible for orientation to the equipment. Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Assistive Technology items from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Vendor with a Business License	Operating Agency	As needed

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Personal Care (SAIL)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	

SAIL Waiver Personal Care Services provide assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

Personal care must be provided by an individual that is qualified and employed by a certified Home Health Agency or other Health Care Agencies approved by the Commissioner of the Alabama Medicaid Agency.

PC services include:

a. Support for activities of daily living, e.g., provided to the recipient and not family members:

-bathing
-personal grooming
-personal hygiene
-meal planning and preparation
-assisting clients in and out of bed
-assisting with ambulation

b. Home Support that is essential to the health and welfare of the recipient, e.g.

-light cleaning
-light laundry
-home safety

c. Basic monitoring of the client, such as skin condition while bathing, excessive sweating, abnormal breathing, abnormal lethargy, and recognition of emergencies.

d. Medication monitoring, e.g., the type that would consist of informing the client that it is time to take medication as prescribed by his or her physician and as written directions on the box or bottle indicate. It does not mean that the PCW is responsible for giving the medicine; however, it does not preclude the PCW from handing the medicine container to the client.

e. Under no circumstance should any type of skilled medical service be performed by the PCW.

f. Personal Care service is not an entitlement. It is based on the needs of the individual client.

g. Personal Care service should not be used for respite care.

Conduct of Service

An individual client record must be maintained by the DSP. The requirements under this section (E) must be documented in each individual client record.

l. The DSP will initiate PC services within three working days of receiving the written contract for services from the case manager. Services must not be provided prior to the authorized start date as stated on the Provider Contract.

2. The DSP will notify the Case Manager within three working days of the following client changes:

a. Client's condition has changed and the Plan of Care no longer meets client's needs or the client no longer appears to need PC services.

b. Client dies or moves out of the service area.

c. Client no longer wishes to participate in a program of PC services.

d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.

3. The DSP will maintain a record keeping system which establishes a client profile in support of units of PC service delivered, based on the Service Provider Contract. The DSP will arrange a daily log reflecting the personal care services provided by the PCWs for the client and the time expended for this service. The daily log must be initialed daily and signed weekly by the client, or family member/responsible person if the client is unable to sign, and the PCW. In the event the client is not physically able to sign and the family member/responsible person is not present to sign, then the PCW must document the reason the log was not signed by the client or family member/responsible person. The daily log must be reviewed and initialed by the Nurse Supervisor at least once every two weeks.

4. The DSP must complete the 60-day supervisory review which includes at a minimum assurance that the services are being delivered consistent with the Plan of Care and the service contract form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the Case Manager within 10 calendar days after the 60-day supervisory review. In the event the client is inaccessible during the time the visit would have normally been made, the review must be completed within five working days of the resumption of PC services.

5. The DSP must have an effective back-up service provision plan in place to ensure that the client receives the PC services as authorized. Whenever the DSP determines that services cannot be provided as authorized, the case manager must be notified by telephone immediately. All missed visits must be reported in writing on Medicaid's WEEKLY MISSED VISIT REPORT form to the case manager on Monday of each week. A missed visit is as follows: When the client is at his/her residence waiting for scheduled services and the services are not delivered. The provider cannot bill for missed visits.

6. Whenever two consecutive attempted visits occur, the case manager must be notified. An attempted visit is when the PCW arrives at the residence and is unable to provide the assigned tasks because the client is not at his/her residence or refuses services. The provider cannot bill for attempted visits.

7. The DSP will develop and maintain a Policy and Procedure Manual subject to approval by the administering agency which describes how activities will be performed in accordance with the terms of the contract and which includes the agency's emergency plan.

8. The DSP will inform clients of their right to complain about the quality of PC services provided and will provide clients with information about how to register a complaint. Complaints which are made against PCWs will be assessed for appropriateness and investigation by the DSP. All complaints which are to be investigated will be referred to the Nurse Supervisor who will take appropriate action. The DSP must maintain documentation of all complaints and follow-ups.

9. The Nurse Supervisor must make the initial visit to the client's residence prior to the start of PC services to review the Plan of Care and in order to give the client written information. For the period of the Public Health Emergency for the COVID-19 pandemic, the Nurse Supervisor may complete initial visits by electronic means. The Plan of Care must be developed and the service contract form submitted prior to the provision of PC services. The DSP must maintain documentation showing that it has complied with the requirements of this section.

10. The Case Manager will authorize PC services by designating the amount, frequency and duration of service for clients in accordance with the client's Plan of Care which is developed in consultation with the client and others involved in the client's care. The DSP must adhere to those duties which are specified in the Plan of Care and the Service Provider Contract. If the DSP identifies PC duties that would be beneficial to the client's care but are not specified in the Plan of Care and the Service Provider Contract, the DSP must contact the Case Manager to discuss the possibility of having these duties included in the Plan of Care and the Service Provider Contract. The decision to modify the duties to be performed by the PCW is the responsibility of the Case Manager, and the Plan of Care and the Service Provider Contract must be amended accordingly. This documentation will be maintained in the client records.

11. The Case Manager will review a client's Plan of Care within three working days of receipt of the DSP's request to modify the Plan of Care.

12. The Case Manager will notify the DSP immediately if a client becomes medically ineligible for waiver services and issue a service contract form terminating the services. The Case Manager must verify Medicaid eligibility on a monthly basis.

13. Under no circumstance should any type of skilled medical service be performed by a PCW.

14. No payment will be made for services not listed on the Plan of Care and the Service Provider Contract.

15. The DSP will retain a client's file for at least five (5) years after services are terminated.

Administrative Requirements

In addition to all conditions and requirements contained elsewhere in this service as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations.

This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP agency. The DSP agency shall notify the administering agency within three working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The agency organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on client care level staff shall be set forth in writing. his information shall be readily accessible to all staff. A copy of this information shall be forwarded to the administering agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP agency and to the administering agency.

3. The DSP agency must have written bylaws or equivalents which are defined as a set of rules adopted by the DSP agency for governing the agency's operations. Such bylaws or equivalent shall be made readily available to staff of the DSP agency and shall be provided to the administering agency upon request.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the DSP agency. A listing of the members of the governing body shall be made available to the administering agency upon request.

6. An annual operating budget, including all anticipated revenue and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to the administering agency prior to the signing of the initial contract with the operating agency. The DSP agency must maintain an annual operating budget which shall be made available to the administering agency upon request.

7. The DSP agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP agency shall furnish a copy of the insurance policy to the administering agency.

8. The DSP agency shall ensure that key agency staff, including the agency administrator or the Nurse Supervisor, be present during compliance review audits conducted by Medicaid, the administering agency and/or its agents.

9. The DSP agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

(Personal care services provided by family members or friends may be covered only if the family members or friends meet qualifications for providers of care; there are strict controls to assure that payment is made to the relative or friends as providers only in return for pc services; there is adequate justification as to why the relative or friend is the provider of care; and proof showing lack of other qualified providers in applicable remote areas. The case manager must have documentation in the client's file showing that attempts were made to secure other qualified providers before a family member or friend is considered.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The Unit of Service will be per 15-minute increments of direct PC service provided in the client's residence. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Provider Contract. The amount of time authorized does not include provider transportation time to and from the client's residence. (Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child, to a recipient's spouse, or to a minor by a parent or stepparent.)

The number of units and services provided to each client is dependent upon the individual's need as set forth in the client's Plan of Care established by the Case Manager. Personal Care Services may be provided for a period not to exceed 100 units (25 hours) per week and/or not to exceed a total of 5,200 units (1300 hours) per waiver year (April 1 - March 31) in accordance with the provider contracting period. Individuals already receiving more than 100 units per week will continue to receive services based on their need as verified in the Plan of Care. (Services may also be reduced based their need.) Medicaid will not reimburse for activities performed which are not within the Scope of Services.

Provider Specifications				
	☐	Individual. List types:	☑	Agency. List the types of agencies:

Provider Category(s) *(check one or both)*:		Home Care Agency or Home Health Agency

Specify whether the service may be provided by *(check each that applies):*	☑	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency	Business	Certificate of Need (CON) if the provider type is a Home Health Agency	Waiver of Certificate of Need approved by the Medicaid Commissioner

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	Alabama Department of Rehabilitation Services Certification Surveyor	Annually upon initial approval by AMA and biannually thereafter if no compliance concerns exist. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Personal Assistance Services (SAIL)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	

Service Definition (Scope)**:**

PAS are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on the job. These activities would be performed by the individual if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform everyday activities on the job. This service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those in competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community which employs individuals with disabilities and there is interaction with non-disabled individuals who are in the same employment setting. This service will be sufficient to support the competitive employment of people with disabilities of at least 40 hours per month. The service will also be sufficient in amount, duration, and scope so that an individual with a moderate to severe level of disability would be able to obtain the support needed maintain employment. A. Objective: The objective of PAS is to provide a range of services designed to assist an individual with physical disabilities to perform activities on the job. B. Provider Experience Agencies desiring to be a provider must have demonstrated to the operating agency (OA) experience in providing PAS or a similar service. C. Description of Services to be Provided 1. This service will be provided to individuals with disabilities inside and outside of their home. It may enable them to maintain employment. The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work. 2. The unit of service will be per 15-minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistants transportation time to or from the recipient's home or place of employment. 3. The PAS received by an individual will be based on the individual's needs. The number of hours must be stipulated on the Plan of Care and Service Provider Contract. 4. IF THIS SERVICE IS USED FOR EMPLOYMENT, THE OA IS REQUIRED TO HAVE A SIGNED AGREEMENT WITH THE EMPLOYER STATING THAT IT IS ACCEPTABLE TO HAVE A PAS WORKER ON THE JOB-SITE. 5. PAS is required, but are not limited to assisting with: Outside Home/Job Site: Essential shopping, transportation to and from work, eating, toileting, medication monitoring, entering or exiting doors. PAS services must be provided under the supervision of the registered nurse who meets the PAS staffing requirements and will: a. Make visits to client's residence after the initial visit by the registered nurse. b. Be immediately accessible by phone during the hours services are being provided. Any deviation from this requirement must be prior approved in writing by the OA and the Alabama Medicaid Agency. If this position becomes vacant the OA must be notified within 24 hours. c. Provide and document supervision of, training for, and evaluation of PAS workers according to requirements in the approved waiver document. d. Provide on-site (client's place of residence) supervision of the PAS worker at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record and reported to the OA. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances of the PAS worker. e. Observe each PAS worker with at least one assigned client at a minimum of every 6 months or more frequently if warranted by substandard performance. This function may be carried out in conjunction with the 60-day supervisory visits, or at another time. Documentation of direct supervisory visits must be maintained in the employee personnel file. f. Assist PAS workers as necessary to provide individual PAS as outlined by the Plan of Care. Any supervision/ assistance given must be documented in the individual client's record. 4. Minimum training requirements must be completed prior to working with a client. The DSP is responsible for providing/or conducting the training. Proof of training must be recorded in the personnel file The PAS training program should stress physical, emotional and developmental needs and ways to work with the population served, including the need for respect of the client, his/her privacy, workplace and property. NOTE: The PAS training program must be approved by the OA. Minimum training requirements must include the following areas: a. Monitor the client, e.g., observe for signs of change in condition, prompt client to take medications as directed, basic recognition of medical problems and medical emergency, basic first aid for emergencies. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods. b. Recordkeeping, e.g., a daily log signed by the client or family member/ responsible person and PAS Worker to document what services were provided for the client in relation to the Plan of Care and signed at least once every two weeks by the supervising nurse. c. Basic Infection Control d. Communication skills e. The

DSP is responsible for providing a minimum of 12 hours relevant in-service training per calendar year. (The annual in-service training requirements can be done on a prorated basis.) Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, location, and outcome of training. Topics for specific in-service training may be mandated by Medicaid or the OA. In-service training may entail furnishing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid, and/or the OA, prior to being offered and may not exceed 4 of the 12 in-service annual training hours. The DSP shall submit proposed program(s) to the OA at least 45 days prior to the planned implementation. Note: In-service training is in addition to the required training prior to delivery of personal care. 5. Personnel files: Individual records will be maintained to document that each member of the staff has met the above requirements. E. Conduct of Service An individual client record must be maintained by the DSP. Requirements under this section (E) must be documented in each individual client record. 1. The DSP will initiate PAS within three working days of receiving the written contract for services from the case manager. Services must not be provided prior to the authorized start date stated on the Provider Contract. 2. The DSP will notify the case manager within three working days of the following client changes: a. Clients condition has changed and the Plan of Care no longer meets client needs or client no longer appears to need PAS. b. Client dies or moves out of service area. c. Client no longer wishes to participate in PAS. d. Knowledge of clients Medicaid ineligibility or potential ineligibility. e. Client becomes unemployed. 3. The DSP will maintain a recordkeeping system which establishes a client profile in support of units of PAS delivered, based on the Service Provider Contract. The DSP will arrange a daily log reflecting the personal assistance services provided by the PAS worker for the client and the time expended for this service. The daily log must be initialed daily and signed weekly by the client, or employer/family member/responsible person if the client is unable to sign. 4. The DSP must complete the 60 day supervisory review which includes at a minimum assurance that the services are being delivered consistent with the Plan of Care and the service contract form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the clients condition. The summary must be submitted to the case manager within ten (10) calendar days after the 60-day supervisory review. 5. The DSP must have an effective back-up service provision plan in place to ensure that the client receives PAS as authorized. 6. Whenever two consecutive attempted visits occur, the case manager must be notified immediately. 7. The DSP will develop and maintain a Policy and Procedure Manual subject to approval by the operating agency which describes how activities will be performed in accordance with the terms of the contract and which includes the agency's emergency plan. 8. The DSP will inform clients of their right to complain about the quality of PAS provided and will provide clients with information about how to register a complaint. 9. The Nurse Supervisor must make the initial visit to the client's residence prior to the start of PAS to review the Plan of Care and in order to give the client written information. The Plan of Care must be developed, and the service contract form submitted prior to the provision of PAS. The DSP must maintain documentation. 10. The case manager will authorize PAS by designating the amount, frequency and duration of service for clients in accordance with the clients Plan of Care which is developed in consultation with the client and others involved in the client's care. The DSP must adhere to those duties which are specified in the Plan of Care and the Service Provider Contract. If the DSP identified PAS duties that would be beneficial to the clients care but are not specified in the Plan of Care and the Service Provider Contract, the DSP must contact the case manager. 11. The case manager will review a client's Plan of Care within three working days of the receipt of the DSPs request to modify the Plan of Care. 12. The case manager will notify the DSP immediately if a client becomes medically ineligible for waiver services and issue a service contract form terminating services. The case manager must verify Medicaid eligibility monthly. 13. Under no circumstance should any type of skilled medical service be performed by a PAS worker. 14. No payment will be made for services not listed on the Plan of Care and Service Provider Contract. 15. The DSP will retain a client's file for at least five years after services are terminated.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work. The unit of service will be per 15-minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistants transportation time to or from the recipient's home or place of employment.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Home Care Agency or Home Health Agency			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Care Agency or Home Health Agency	Business	Certificate of Need (CON) if the provider type is a home health agency	Waiver of Certificate of Need approved by the Medicaid Commissioner

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Care Agency or Home Health Agency	Alabama Department of Rehabilitative Services Certification Surveyor	Annually upon initial approval and bi-annually thereafter if no compliance concerns exist. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification					
Service Title:	Respite (SAIL)				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Definition (Scope)**:** Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care. Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household. Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the PCCP.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service: The unit of service is fifteen (15) minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Workers (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime. This service is limited to 300 hours/year and is dependent upon the individual client's need as set forth in the clients PCCP established by the Case Manager.					
Provider Specifications					
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:	
	Respite Care Worker - Unskilled				
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian	
Provider Qualifications (*provide the following information for each type of provider)*:					
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*		

Respite Care Worker – Unskilled			This service will be performed by non-licensed personnel who possess the ability to read and write, as well as the ability to work independently on an established schedule and can follow the plan of care with minimal supervision. Unskilled Respite Workers must meet the same orientation and in-service requirements as a Personal Care Worker and submit to a program for testing, prevention and control of tuberculosis. The following temporary modifications apply: The initial training for new employees may be performed via other means during the pandemic period. The training may be performed via telephone, webinars, or other online training. The annual training may be delayed during the pandemic period or conducted via electronic methods.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Respite Care Worker - Unskilled	ADRS	Verified initially and bi-annually thereafter. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Case Management (SAIL)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:** Case Management (CM) Services assist individuals who receive waiver services in gaining access to needed and desired waiver and other State Plan services, as well as needed medical, social, educational and other appropriate services, regardless of the funding source for the services to which access is gained. CM services may be used to locate, coordinate, and monitor necessary and appropriate services. CM activities can also be used to assist in the transition of an individual from institutional settings, such as hospital, and nursing facilities into community settings. The case manager will assist in the coordination of services that help maintain an individual in the community. CM activities may also serve to provide necessary coordination with providers of non-medical and non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which the person may be eligible. Case managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care. CM is a waiver service available to all SAIL Waiver clients. Case Managers assist clients to make decisions regarding long term care services and supports. CM ensures continued access to waiver and non-waiver services that are appropriate, available and desired by the client.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: The amount, frequency or duration of this service is dependent upon the participant needs as set forth in the Plan of Care for regular waiver case management. The unit of service will be per 15-minute increments commencing on the date that the client is determined eligible for the State of Alabama Independent Living (SAIL) Waiver services and entered into the Medicaid Long Term Care (LTC) file. Case Management service provided prior to waiver approval should be considered administrative. At least one face-to-face visit is required each month in addition to any other case management activities. The following temporary modification applies: All face to face visits will be waived and visits will occur by telephone or video conference. A unit of service for Case Management that assists in the transitioning of individuals from institutional settings into the community will be per 15-minute increments beginning on the first date the case manager goes to the institution to complete an initial assessment. There is a maximum limit of 180 days under the HCBS waiver to assist an individual to transition from an institution to a community setting. During this period it is required that the case manager make at least 3 face-to-face visits and have monthly contact with the individual or sponsor. The following temporary modification applies: All face to face visits will be waived and visits will occur by telephone or video conference. For Transitional CM a unit of service that assists individuals transitioning from institutional settings into the community will be fifteen (15) minutes beginning on the first date the case manager goes to the institution to complete an initial assessment. If Transitional CM is provided it should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate. In instances in which services are offered by a relative, the State will ensure that there is no conflict of interest by prohibiting the relative who is the direct service provider from participating in the plan of care development and signing the service authorization log if the recipient is unable to do so. The ADRS Case Manager will monitor these instances to ensure that the relative who is the direct service provider is providing the waiver services according to the plan of care.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				State Agency--Case Management staff are employees of a state agency (ADRS).

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
State Agency--Case Management staff are employees of a state agency (ADRS).	Professionals having earned a Master of Arts degree or a Master of Science degree, preferably in Rehabilitation counseling or related field, from an accredited college or university, or having earned a degree from an accredited School of Nursing. Transitional Case Management Services may be delivered by a SAIL employed possessing a BS degree in social work, psychology, or related field who has provided services an Independent Living Specialist. Transitional Case Management Services will also be conducted by case managers who meet the minimum accredited college/university qualifications described above.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

State Agency--Case Management staff are employees of a state agency (ADRS).	ADRS staff is responsible for verifying date of expiration of license of the case management staff.	Verification of provider qualifications is monitored annually. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Medical Supplies (SAIL)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	

Service Definition (Scope)**:** Medical supplies include devices, controls and/or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, and to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Specialized Medical Supplies authorized in an individual's care plan as of the date of the COVID 19 PHE, including adult protective undergarments, catheter bags and other supplies covered under that service; and for nonprescription Assistive Technology authorized in an individual's care plan as of the date of the COVID-19 PHE. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.

A. Objective:
The objective of the Medical Supplies service is to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization. Medical supplies ensure health and safety for the duration of usefulness of supplies. Medical supplies are necessary for the care and functional capabilities of the recipient in the home.
B. Provider Experience
Providers of this service will be those who have a signed provider agreement with the Department of Rehabilitation Services. The case manager must provide the participant with a choice of vendors in the local area of convenience.
C. Description of Services to Be Provided
1. Medicaid will pay for a service when the service is covered under the SAIL Waiver and is medically necessary. Medically necessary means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each recipient must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.
2. Medical supplies are necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization.
3. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-Tips, etc.
4. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.
5. All items shall meet applicable standards of manufacture, design and installation.
Supplies are limited to $2,100.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipients.
D. Conduct of Service
1. This service will only be provided when prescribed by the recipient's physician.
2. Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Rehabilitation Services. Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Specialized Medical Supplies and Assistive Technology items from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic. 3. Supplies must be indicated on the recipients Plan of Care, they must be medically necessary to maintain the recipient's ability to remain in the home and live independently.
4. Reimbursement for medical supplies shall be limited to $2,100.00 annually per recipient. Receipt for all supplies purchased must be kept in the recipient's case record.
5. The case manager must provide the recipient with a choice of vendors in the area. A signed Participant Choice of Vendor form should be placed in the case file and a copy provided to the participant. Services should not be denied due to an absence of the signature of the recipient.
6. Any supplies that are covered under the State DME program cannot be billed as a waiver item. It must be billed through the State DME procedure codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Medical Supplies are limited to $2,100.00 per recipient per year. The OA must maintain documentation of items purchased for recipient.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Certified Waiver Provider			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Waiver Provider	.		Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency, and the Department of Rehabilitation Services. The case manager must provide the participant with a choice of vendors in the local area of convenience. Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Specialized Medical Supplies and Assistive Technology items from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.

Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Certified Waiver Provider	ADRS Certification Surveyor		Prior to contract approval, annually or bi-annually for approved providers based on previous score, or more often if needed based on service monitoring concerns. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.
Service Delivery Method			
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑ Provider managed

Service Specification	
Service Title:	Assistive Technology (SAIL)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	

Service Definition (Scope)**:**
Assistive Technology includes devices, pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisitions, selection, design, fitting, customizing, adaptation, application, etc. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. This service is necessary to prevent institutionalization or to assist an individual to transition from an institution to the SAIL Waiver. All items shall meet applicable standards of manufacture, design and installation. A. Objective: The objective of Assistive Technology service is to increase, maintain or improve functional capabilities for individuals with disabilities. It will also help ensure the health and safety for the recipient which enables them to function with greater independence in their current residence. B. Provider Qualifications: Businesses providing Assistive Technology services will possess a business license. Vendors are responsible for client orientation to the equipment. C. Description of Services to be Provided: 1. The SAIL Waiver program will pay for equipment when it is not covered under the regular State Plan and is medically necessary. Medically necessary means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records on each recipient must substantiate the need of services, must include all findings and information supporting medical necessity, and must detail all treatment provided. Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation NET) Services have been exhausted. 2. Assistive Technology includes pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities individuals with disabilities. 3. The amount for this service is $25,000.00 per waiver recipient. Any expenditure in excess of $25,000.00 must be approved by the SAIL State Coordinator. 4. The service may also be provided to assist an individual to transition from an institutional setting to the home and community based waiver. Transitional Assistive Technology will be limited to hospital beds, Hoyer lifts, and/or wheelchairs (manual or electric). The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate. D. Conduct of Service 1. Assistive Technology must be ordered by the physician. It must be documented in the Plan of Care and case narrative. The case manager must have the prescription for Assistive Technology before requesting prior approval. Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Assistive Technology authorized in an individual's care plan as of the date of the COVID-19 PHE. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K. 2. To obtain prior authorization numbers for this service, the case manager must submit a copy of the following documents: a. Medicaid Prior Authorization Form #342 b. Price quotation list from the company supplying the recipient with equipment and specifying the description. c. A copy of the physician's prescription. Copies must be legible. Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Assistive Technology authorized in an individual's care plan as of the date of the COVID-19 PHE. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K. 3. Assistive Technology must be prior authorized and listed on the client's Plan of Care. The prior authorization packet is submitted to ADRS by the case manager and ADRS submits prior authorization requests using the Medicaid Prior Authorization Form (342). Prior authorization is also required for Transitional Assistive Technology. 4. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate. 5. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service. 6. The case manager should secure an EOMB (Explanation of Medicare Benefits) from the vendor if Medicare can be applied towards purchase before the final payment will be processed for Assistive Technology. Explanation of benefits should also be secured if the recipient has other insurance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: The amount for this service is $25,000.00 per waiver recipient. Any expenditure in excess of $25,000.00 must be approved by the state coordinator. Transitional Assistive Technology will be limited to hospital beds, Hoyer lifts, and/or wheelchairs (manual or electric).

Provider Specifications				
Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Vendor with a Business License			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vendor with a Business License	Business		Vendor is responsible for orientation to the equipment. Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Assistive Technology items from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Vendor with a Business License	Case Manager	As needed

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Personal Care/Attendant Services (TA)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:** Personal Care/Attendant Services: PC/AS provides in-home and out-of-home (job site) assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair and vice versa, ambulation, maintain continence, medication management and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provide with ADLs or essential to the health and welfare of the participant rather than the participant's family**.**	
Specify applicable (if any) limits on the amount, frequency, or duration of this service: This service will be provided to individuals with disabilities inside and outside of their home. It may enable waiver participants to enter or to maintain employment. The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work. The unit of service will be in 15-minute increments, of direct PC/AS Service provided either in the participant's residence or another setting outside of the home. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form or Service Provider contract. The amount of time authorized does not include transportation time to and from the participant's residence or place of employment or the Personal Care/Attendant Service worker's break or mealtime. The number of units and service provided to each participant is dependent upon the individual participant's needs as set forth in the participant's Plan of Care established by the case manager, if case management is elected by the participant, and subject to approval by the Alabama Medicaid Agency (AMA). Medicaid will not reimburse for activities performed which are not within the scope of services. If this service is being used for employment, the AMA will have a signed agreement with the employer stating that it is acceptable to have a PC/AS Worker on the job site. Under this 1915c, relatives can be hired as providers of services if they are employed by an approved provider. Under the state's 1915j, a TA Waiver recipient can choose the individual that will provide their care. Under the 1915j, a worker can be a relative, legal guardian, or legally responsible person.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Home Health/Home Care Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health/Home Care Agency	Business	Certificate of Need (CON)if the provider is not a Home Health Agency	Waiver of Certificate of Need approved by the Medicaid Commissioner

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health/Home Care Agency	Alabama Department of Senior Services	Annually upon initial approval by AMA and biannually thereafter if no compliance concerns exist. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Medical Supplies (TA)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Medical Supplies and Appliances: Medical supplies and appliances includes devices, controls or appliances specified in the Plan of Care, not presently covered under the State Plan, which enables the individual to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Waiver medical supplies and appliances do not include over-the-counter personal items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds will be an addition to any medical supplies furnished under the State Plan and excludes those items which are not of direct medical or remedial benefit to the individual.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
All waiver medical supplies and appliances must be prescribed by a physician and be specified in the Plan of Care. Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Assistive Technology authorized in an individual's care plan as of the date of the COVID-19 PHE. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Durable Medical Equipment Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Durable Medical Equipment Provider	State of Alabama business license		Code of Alabama, 1975, 34-14-C-3

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Durable Medical Equipment Provider	AMA-TA Waiver Coordinator	Initially then Annually. For existing providers, the state will suspend follow-up verifications of provider qualifications that come due during the pandemic, but will resume such verifications by the end of the month in which the Public Health Emergency ends. Upon resumption, all suspended verifications will be completed within 90 days. This does not apply to initial verifications for new providers, which the state will continue to complete throughout the PHE period.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Service Specification	
Service Title:	Assistive Technology (TA)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:** Assistive technology includes devices, equipment or products that are modified, customized and is used to increase, maintain or improve functional capabilities of individuals with disabilities as specified in the Plan of Care. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an assistive technology device. Such services may include acquisition, selection, design, fitting, customizing, adaption, application, etc. Items reimbursed with waiver funds exclude items which are not of direct medical benefit to the recipient. Receipt of this service to prevent institutionalization will be documented in the medical record. All items must meet applicable standards of manufacturer, design and installation. Repairs and maintenance of assistive technology devices are included in this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: The assistive technology item must be ordered by a physician, documented on the Plan of Care and must be prior authorized and approved by the Alabama Medicaid Agency's or its designee. Temporarily allow verbal orders from a physician or other licensed health care provider for non-prescription Assistive Technology authorized in an individual's care plan as of the date of the COVID-19 PHE. This modification will be in effect beginning March 13, 2020 and extend through the end of the month in which the PHE terminates, not to exceed the end date of the approved Appendix K.

To obtain prior authorization for the service, the Case Manager must submit a copy of the following documents:

1. An agreement between the AMA and the company providing the service;
2. A price quotation list from the company supplying the equipment, providing a description of the item;
3. A legible copy of the physician's prescription for the item; and

Note: The case manager must inform providers that they have to submit the Medicaid Prior Authorization Form (Form #342) to the TA waiver nurse reviewer for approval.

Upon completion of service delivery, the participant must sign and date acknowledging that they are satisfied with the service. Providers of assistive technology shall be capable of supplying, maintaining and training in the use of assistive technology devices.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Assistive Technology Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Assistive Technology Provider	State of Alabama Business License		Code of Alabama, 1975, 34-14-C-3 Providers may be reimbursed at the approved waiver service limits, per existing Waiver limits and guidelines, when purchasing Assistive Technology items from any available vendor, regardless of inclusion on the existing approved vendor list, who can provide necessary and potentially short-supplied items in stock when supply shortages or costs are impacted by circumstances related to the COVID-19 pandemic.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assistive Technology Provider	AMA-TA Waiver Coordinator	Initially then Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

[i] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.