

# APPENDIX K: Emergency Preparedness and Response

**Background:**

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. 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.<sup>i</sup> This appendix may be completed retroactively as needed by the state.

## Appendix K-1: General Information

**General Information:**

A. State: Ohio

B. Waiver Title: Assisted Living, Ohio Home Care Waiver, My Care Ohio, PASSPORT

C. Control Number: 0446.R03.01, 0337.R04.06, 1035.R01.02, 0198.R06.03.

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

<input checked="" type="checkbox"/>	Pandemic or Epidemic
<input type="checkbox"/>	Natural Disaster
<input type="checkbox"/>	National Security Emergency
<input type="checkbox"/>	Environmental
<input type="checkbox"/>	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.

On March 11, 2020, the World Health Organization declared the rapidly spreading coronavirus (COVID-19) outbreak will likely spread to all countries around the globe. Earlier, on March 9, 2020, Ohio Governor Mike DeWine declared a statewide state of emergency to protect the health, safety and well-being of Ohioans from the dangerous effects of COVID-19. All citizens have been urged to heed the advice of the Ohio Department of Health (ODH) and other emergency officials regarding this public

health emergency. State agencies, including those serving individuals through Ohio Medicaid, are authorized to coordinate the State response to COVID-19, and to develop and implement procedures, including suspending or adopting temporary rules within an agency's authority, consistent with recommendations from ODH designed to prevent or alleviate this public health threat. The Ohio Department of Medicaid (ODM) is submitting this Appendix K for the purpose of establishing processes aimed at reducing risks and ensuring access to home and community-based services (HCBS) to individuals through the Assisted Living, Ohio Home Care, MyCare Ohio, and PASSPORT waiver programs who are at greatest risk from COVID-19.

Current enrollment on each of the three waivers is as follows:

- Assisted Living: 3,552
- Ohio Home Care: 6,800
- MyCare Ohio: 29,451
- PASSPORT: 20,602

Slots for the respective waivers are as follows:

- Assisted Living: 5,199 in waiver year 1
- Ohio Home Care: 9,200 in waiver year 4
- MyCare Ohio: 33,409 in waiver year 2
- PASSPORT: 33,975 in waiver year 2

The Ohio Home Care serves individuals birth through age 59, and the MyCare Ohio waiver programs serve individuals ages 18 and older. The Assisted Living program serves individuals age 21 and older and the PASSPORT program serves individuals aged 60 and older. All these waivers require a skilled or intermediate level of care (considered by the State to meet nursing facility (NF) level of care) for enrollment. The State is assuming all enrolled individuals on the Assisted Living, Ohio Home Care, MyCare Ohio, and PASSPORT programs are currently at risk of contracting the infection which causes COVID-19.

The Ohio Department of Medicaid (ODM), the State Medicaid agency, is responsible for administration and oversight of the Ohio Home Care Waiver and MyCare Ohio Waiver programs. ODM contracts with multiple case management agencies (CMA) to provide assessment and case management services. The CMAs operate regionally around the state and are responsible for interfacing with individuals at the local level to assure access to services. CMA staff perform level of care assessments, as well annual and event-based reassessments, work with each waiver individual to develop/update person-centered service plans tailored to meet their specific needs, monitor health and welfare, and provide ongoing case management and support. ODM also contracts with a single entity to perform provider management and oversight functions and to conduct provider oversight and incident investigations.

The Ohio Department of Medicaid (ODM) maintains oversight of operational and policy development at Ohio Department of Aging (ODA) through an interagency agreement between ODM and ODA, and thirteen three party agreements with ODM, ODA and the PAAs. These agreements provide for ODM reviews of programmatic compliance with federal and state laws and regulations and both auditing and fiscal compliance. The PAAs, which serve as ODA's designee as outlined in the agreement, are delegated responsibility for the daily operation of the Assisted Living and PASSPORT waiver as designated regional entities. ODA is primarily responsible for monitoring the PAAs compliance with state and federal law and policies relative to waiver operations.

The State is seeking approval from CMS to make changes to the following:

**F. Proposed Effective Date: Start Date: 1/27/2020 Anticipated End Date: 1/26/2021**

**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:***

Please see accompanying documentation for State Disaster Plan.

**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]

The State permits individuals enrolled on the Ohio Home Care Waiver program who reach their 60<sup>th</sup> birthday to remain enrolled on the waiver for the duration of the emergency. Individuals are to be disenrolled from the Ohio Home Care Waiver at their next face-to-face assessment following the expiration of the emergency.

b. X Services

i.

\_\_\_ Temporarily modify service scope or coverage.

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]

The State permits delivery of bulk meals as not to exceed a total of what would constitute 2 meals per day.

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).

iv. X 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]:

K-2-b-iv: The State permits the following:

- The State permits expanding settings where services, including but not limited to personal care, adult day, and out of home respite, can be furnished.
- Adult day health services may be provided in the waiver participant's home.
- Out of Home Respite services may be provided in an unlicensed setting that is approved by the Ohio Department of Medicaid or the Ohio Department of Aging. Room and Board is not included in the respite rate.

The State permits the use of living units in ODA-certified assisted living facilities which are not single occupancy living units with full bathrooms during the timeframe identified in the approved Appendix K.

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

c. **X** **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.

K-2-c: The State permits the following:

- Permit payments for direct care services rendered by family caregivers and legally responsible individuals when not already permitted in the waiver.

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.]

K-2-d-i: The State permits the following:

- Allow waiver providers with an active Medicaid provider agreement to furnish waiver services across the delivery systems without being subject to additional provider standards and certification processes specific to the waiver programs.

All provider types which furnish the same or similar services between delivery systems are subject to the minimum Standards described below:

Ohio Department of Aging (ODA) -certified waiver providers meet the minimum standards to furnish the same or similar waiver services in the Ohio Department of Medicaid (ODM) operated waivers and the Ohio Department of Developmental Disabilities (DODD) operated waivers.

ODM-approved waiver providers meet the minimum standards to furnish the same or similar services in the ODA operated waivers and the DODD operated waivers.

DODD-certified waiver providers meet the minimum standards to furnish same or similar waiver services in the ODM operated waivers and the ODA operated waivers.

ii. \_\_\_ **Temporarily modify provider types.**

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

**iii. X 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.]

K-2-d-iii: The State permits the following:

- The State may suspend structural compliance reviews.

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

K-2-e: The State permits the following:

- The State permits the face-to-face assessment requirement to be replaced with telephonic contact and desk reviews. Telephonic assessments will be conducted in accordance with HIPAA.
- The assessment must be validated at the next face-to-face visit.

**f. 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].

**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.]

K-2-g: The State permits the following:

- Allowing face-to-face assessment requirements to be replaced with telephonic contact conducted in accordance with HIPAA.
- Service authorizations and adjustments may be made based on telephonic assessment of need.
- All services may be authorized telephonically except for the following: home maintenance and chore services, and home modification services.  
Existing service authorizations may be extended via telephonic contacts in accordance with HIPAA. In the event a written or electronic signature for the waiver service plan cannot be obtained, the State has an established process for collecting the individual's standard signature via regular mail, dated the date of the person-centered service plan meeting.

**h. Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances.**

**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. 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.]

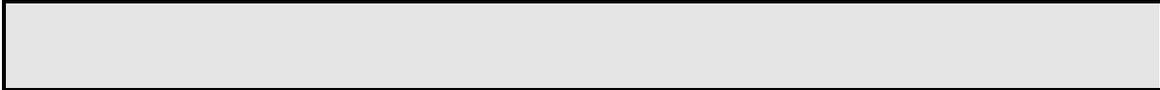
**k. Temporarily institute or expand opportunities for self-direction.**

[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. X 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]. ]**

K-2-m: The State permits the following:

- Contact Schedules – face-to-face requirements may be replaced with telephonic contacts which are conducted in accordance with HIPAA. The CMA must prioritize individuals at the highest risk levels for face-to-face visits.
- Payer Sequencing: Flexibility with the payor sequencing requirements to permit the individual to access a service via either the State plan or the waiver based on provider availability and immediate health and safety needs. The individual will not exceed any limits imposed in the State plan and waiver in their totality. The State will ensure there is no duplication of coverage provided under the State plan, EPSDT and waiver services.

## 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.

### 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
  - ii.  Personal care services that only require verbal cueing
  - 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).
  - 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)
- 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.
  - b.  Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
  - c.  Adjust prior approval/authorization elements approved in waiver.
  - d.  Adjust assessment requirements
  - e.  Add an electronic method of signing off on required documents such as the person-centered service plan.
- 

## Contact Person(s)

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

**First Name:** Icilda  
**Last Name** Dickerson  
**Title:** Chief  
**Agency:** Bureau of Long-Term Services and Supports  
**Address 1:** Ohio Department of Medicaid  
**Address 2:** 50 West Town Street, Fifth Floor, P.O. Box 182709  
**City** Columbus  
**State** Ohio  
**Zip Code** 43215  
**Telephone:** (614) 752-3578  
**E-mail** Icilda.Dickerson@medicaid.ohio.gov  
**Fax Number** (466) 466-6945

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

**First Name:** Click or tap here to enter text.  
**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:** 5/4/2020

\_\_\_\_\_/S/\_\_\_\_\_  
State Medicaid Director or Designee

**First Name:** Maureen M.  
**Last Name** Corcoran  
**Title:** Director  
**Agency:** Ohio Department of Medicaid  
**Address 1:** 50 West Town Street, Fifth Floor  
**Address 2:** P.O. Bo 182709  
**City** Columbus  
**State** Ohio  
**Zip Code** 43215  
**Telephone:** (614) 752-5024  
**E-mail** [Maureen.Corcoran@medicaid.ohio.gov](mailto:Maureen.Corcoran@medicaid.ohio.gov)  
**Fax Number** (614) 644-4368

## Section A---Services to be Added/Modified During an Emergency Assisted Living, My Care Ohio, PASSPORT Waivers

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. 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).

Service Title:	Adult Day Health Service (PASSPORT and MyCare)		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
Service Definition (Scope):			
Adult Day Health Services (ADHS) - ADHS are regularly scheduled services delivered at an ADHS center which is a non-institutional, community-based setting, electronically, or in the individual's home. The ADHS service includes recreational and educational programming to support the individual health and independence goals and health status monitoring. When the service is delivered in the community-based setting or the individual's home, the provider must furnish at least one meal, but no more than two meals per day that meet the individual's dietary requirements. When the service is delivered in a community-based setting, the ADHS center may also make available health status monitoring, skilled therapy services, and transportation to and from the ADHS center.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
<b>Provider Specifications</b>			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	X Agency. List the types of agencies:
			Adult Day Center, Social Service Agency, Nursing Facilities, Community Action Agency, Churches (PASSPORT)
			Adult Day Center, Social Service Agency, Nursing facilities, Community Action Agency, Churches Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agency. (MyCare)
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>

<p>Agency (PASSPORT)</p>		<p>ODA certification as a LTC agency provider:  OAC 173-39-03 - This rule describes the certification process for community-based long-term care services beginning with the request for the application and concluding with the final description of how ODA issues the certification.  OAC 173-39-02. Conditions of Participation for PASSPORT Services. This rule establishes the requirements and scope of responsibility related to service delivery and documentation.  OAC 173-39-02.1 – Adult Day Service Specifications. This rule establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.</p>	<p>Compliance with HCBS settings characteristics (OAC 5160-44-01)  Medicaid provider agreement with ODM (OAC 5160-1-17.2)</p>
------------------------------	--	---	---

Adult Day Center, Social Service Agency, Nursing facilities, Community Action Agency, Churches Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agency. (MyCare)			<p>Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:</p> <p>ODA certified provider: Compliance with OAC chapters 5160-44, 173-39, including 173-02</p> <p>ODM approved provider: Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46</p>

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency (PASSPORT)	Ohio Department of Aging (ODA) ODA's designee	In accordance with OAC 173-39-04
Adult Day Center, Social Service Agency, Nursing facilities, Community Action Agency, Churches Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agency. (MyCare)	<p>ODA or its designee for ODA-certified providers.</p> <p>ODM or its designee for ODM-approved providers.</p> <p>The ICDS plan as part of its credentialing and recredentialing processes will verify that the provider has an active Medicaid provider agreement to furnish waiver services.</p>	<p>ODM: Verification of provider qualifications is conducted in accordance with OAC 5160-45-06.</p> <p>ODA: Verification of provider qualifications is conducted in accordance with OAC 173-39-04</p>

**Service Delivery Method**

<b>Service Delivery Method</b> (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
--	--------------------------	---	-------------------------------------	------------------

**Service Specification**

Service Title: Out of Home Respite (PASSPORT and MyCare)

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

**Service Definition (Scope):**

Out-of-home respite services are services delivered to individuals in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay. The services the out-of-home respite provider must make available are:

- 1) Waiver nursing
- 2) Personal care aide services
- 3) Three meals per day that meet the individual's dietary requirements.

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

The services delivered by an Out-of-Home Respite service provider cannot be reimbursed separately. Out-of-Home Respite Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	X	Agency. List the types of agencies:
				ICF-IID, NF, or another setting approved by Ohio Department of Medicaid or certified by ODA (PASSPORT)
				NF and other institutional providers (e.g., hospitals, etc.) (MyCare)

Specify whether the service may be provided by *(check each that applies)*:

<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
--------------------------	----------------------------	--------------------------	-------------------------

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

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
----------------	--------------------------	------------------------------	---------------------------------

<p>Agency (PASSPORT)</p>	<p>NF per OAC rule 5160-3-02 ICF-IID that has an active Medicaid provider agreement in accordance with Sections 5124.06 and 5124.07 of the Revised Code.</p>	<p>ODA certification as a LTC agency provider: OAC 173-39-03 This rule describes the certification process for community-based long-term care services beginning with the request for the application and concluding with the final description of how ODA issues the certification. OAC 173-39-02 Conditions of Participation for PASSPORT Services. This rule establishes the requirements and scope of responsibility related to service delivery and documentation. OAC 173-39-02.23 Out of Home Respite Service specifications. This rule establishes the parameters for the type of tasks and describes the timelines and documentation requirements for the service.</p>	
------------------------------	--	---	--

NF and other institutional providers (e.g., hospitals, etc.) (MyCare)	NF per OAC rule 5160-3-02		<p>Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.</p> <p>ODA certified providers: Compliance with OAC Chapter 5160-44, 173-39, including 173-39-02.23</p> <p>ODM approved providers: Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46</p>
<b>Verification of Provider Qualifications</b>			
<b>Provider Type:</b>	<b>Entity Responsible for Verification:</b>		<b>Frequency of Verification</b>
Agency	Ohio Department of Aging ODA's designee		In accordance with OAC 173-39-04
NF and other institutional providers (e.g., hospitals, etc.) (MyCare)	<p>ODM or its designee for ODM-approved providers</p> <p>ODA or its designee for ODA certified providers</p> <p>The ICDS plan as part of its credentialing and recredentialing processes will verify that the provider has an active Medicaid provider agreement to furnish waiver services.</p>		<p>ODM-approved providers - Verification of provider qualifications is conducted in accordance with OAC 5160-45-06</p> <p>ODA certified providers: Verification if provider qualification is conducted in accordance with OAC 173-39-04</p>
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

**Service Specification**

Service Title: Personal Care (PASSPORT)

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

Service Definition (Scope):

The service furnishes hands-on assistance with activities of daily living (ADLs) in the home and in the community. Tasks include: bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, position in bed, transferring, range of motion exercise, and monitoring intake and output.

The service also furnishes hands-on assistance with instrumental activities of daily living (IADLs) in the home and in the community that are incidental to the provision of hands-on assistance with ADLs but may not comprise the entirety of the service. Tasks include: general homemaking activities including, but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming and waste disposal. Household chores including but not limited to washing floors, windows and walls, taking down loose rugs and tiles, and moving heavy items to provide safe access and exit.

The service does not include tasks performed by a licensed health professional, including skilled or nursing care.

The service is intended to complement, not replace, similar services available under the Medicaid state plan. The waiver service shall not be used in lieu of the Medicaid state plan home health benefit when it has been determined the individual meets the eligibility criteria as defined in OAC 5101:3-12-01 to receive the service.

When the service is delivered by an individual provider type, the participant-directed employee may not perform any health-related elements of the service (skilled care, nursing, medication administration) that, by state law, only licensed medical professionals can deliver. The individualized service plan will describe how routine health related tasks will be met through the use of agency based providers. For all other tasks permitted under the PASSPORT personal care service, a waiver participant may use a combination of participant-directed individual providers and agency-based provider managed services.

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

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Qualified consumer-directed provider		Home Health Agency, Social Service Agency, Hospitals,
		Non-agency provider		

Specify whether the service may be provided by <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	<b>Legally Responsible Person</b>	<input checked="" type="checkbox"/>	<b>Relative/Legal Guardian</b>
--	-------------------------------------	-----------------------------------	-------------------------------------	--------------------------------

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

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
----------------	--------------------------	------------------------------	---------------------------------

<p>Agency</p>		<p>ODA certification as a LTC agency provider:</p> <p>OAC 173-39-03 This rule describes the certification process for community-based long-term care services beginning with the request for the application and concluding with the final description of how ODA issues the certification.</p> <p>OAC 173-39-02 - Conditions of Participation for PASSPORT Services. This rule establishes the requirements and scope of responsibility related to service delivery and documentation.</p> <p>OAC 173-39-02.11 – Personal Care Service Specifications. This rule establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.</p> <p>OR</p> <p>An ODM approved provider for the</p>	<p>Compliance with HCBS settings characteristics (OAC 5160-44-01). Medicaid Provider agreement with ODM (OAC 5160-1-17.2)</p>
---------------	--	---	---

		same or similar service  OR A DODD certified provider for the same or similar service	
--	--	--	--

<p><b>Individual</b></p>		<p>ODA certification as a long term care consumer directed individual provider:</p> <p>OAC 173-39-02 Conditions of Participation for PASSPORT Services. This rule establishes the requirements and scope of responsibility for agency and individual providers</p> <p>OAC 173-39-03 This rule describes the certification process for agency and individual providers of community-based long-term care services beginning with the request for the application and concluding with the final description of how ODA issues the certification.</p> <p>OAC 173-39-02.11 – Personal Care Service Specifications. This rule establishes the parameters for the type of tasks, describes the agency and individual provider qualifications and documentation requirements for this service.</p>	<p>Consumer-directed provider agreement Compliance with HCBS settings characteristics (OAC 5160-44-01). Medicaid Provider agreement with ODM (OAC 5160-1-17.2)</p>
--------------------------	--	---	--

		OR An ODM approved provider for the same or similar service  OR A DODD certified provider for the same or similar service	

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	Ohio Department of Aging (ODA) ODA's designee	In accordance with OAC 173-39-04.
Individual	Ohio Department of Aging (ODA) ODA's designee	In accordance with OAC 173-39-04

**Service Delivery Method**

<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
---	-------------------------------------	---	-------------------------------------	------------------



Service Specification			
Service Title:	Waiver Nursing (PASSPORT and MyCare)		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
Service Definition (Scope):			
Waiver nursing are part-time, intermittent and/or continuous nursing services provided to individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. Waiver nursing services are furnished within the nurse's scope of practice as set forth in Chapter 4723 of the Revised Code (Ohio's Nurse Practice Act) and Administrative Code rules adopted thereunder.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The service is intended to complement, not replace, similar services available under the Medicaid state plan and EPSDT services.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Non-agency employed RN; non-agency employed LPN	Medicare-certified HHA, ACHC-CHAP-accredited agency, and Joint Commission-accredited agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>

<p><b>Individual</b></p>		<p>ODA certification as a LTC non-agency provider.  OAC 173-39-03  This rule describes the certification process for community-based long-term care services beginning with the request for the application and concluding with the final description of how ODA issues the certification.  OAC 173-39-02  Conditions of Participation for PASSPORT Services. This rule establishes the requirements and scope of responsibility related to service delivery and documentation.  OAC 173-39-02.22  Waiver Nursing Service Specifications. This rule establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.  OR  ODM-approved as a provider for the same or similar service;  OR</p>	<p>Compliance with HCBS settings characteristics (OAC 5160-44-01).  Valid Medicaid provider agreement (OAC 5160-1-17.2).</p>
--------------------------	--	--	--

		DODD-certified provider for the same or similar service.	
--	--	--	--

<p><b>Agency</b></p>		<p>ODA certification as a LTC agency provider.</p> <p>OAC 173-39-03 This rule describes the certification process for community-based long-term care services beginning with the request for the application and concluding with the final description of how ODA issues the certification.</p> <p>OAC 173-39-02 Conditions of Participation for PASSPORT Services. This rule establishes the requirements and scope of responsibility related to service delivery and documentation.</p> <p>OAC 173-39-02.22 Waiver Nursing Service Specifications. This rule establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.</p> <p>OR</p> <p>ODM-approved as a provider for the same or similar service;</p>	<p>Compliance with HCBS settings characteristics (OAC 5160-44-01).</p> <p>Valid Medicaid provider agreement (OAC 5160-1-17.2).</p>
----------------------	--	---	--

		OR DODD-certified provider for the same or similar service.	

<b>Verification of Provider Qualifications</b>		
<b>Provider Type:</b>	<b>Entity Responsible for Verification:</b>	<b>Frequency of Verification</b>
Individual	Ohio Department of Aging (ODA)	In accordance with OAC 173-39-04
Agency	ODA's designee	In accordance with OAC 173-39-04

Service Specification			
Service Title:	Homemaker (PASSPORT and MyCare)		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
Service Definition (Scope):			
<p>Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.</p> <p>Homemakers may also assist the participant to manage personal appointments, day-to-day household activities, and to ensure that the participant maintains his/her current living arrangement by acting as a travel attendant</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Home Health Agency, Social Service Agency, Hospitals (Both PASSPORT and MyCare)
Specify whether the service may be provided by <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>

<p><b>Agency</b></p>		<p>ODA-certification as a LTC agency provider:</p> <p>OAC 173-39-03. This rule describes the certification process for community-based long-term care services beginning with the request for the application and concluding with the final description of how ODA issues the certification.</p> <p>OAC 173-39-02. Conditions of Participation for PASSPORT Services. This rule establishes the requirements and scope of responsibility related to service delivery and documentation.</p> <p>OAC 173-39-02.8 - Homemaker Service Specifications. This rule establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.</p> <p>OR</p> <p>ODM-approved as a provider for the</p>	<p>Compliance with HCBS settings characteristics (OAC 5160-44-01). Valid Medicaid provider agreement (OAC 5160-1-17.2).</p>
----------------------	--	--	---

		same or similar service;  OR DODD-certified provider for the same or similar service	

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency	Ohio Department of Aging (ODA) ODA's designee The ICDS plan as part of its credentialing and recertification processes will verify that the provider has an active Medicaid provider agreement to furnish waiver services.	In accordance with OAC 173-39-04

Service Delivery Method				
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed



**Service Specification**

Service Title: Home Care Attendant (PASSPORT and MyCare)

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

**Service Definition (Scope):**

Home care attendant services include all of the following tasks when provided by an unlicensed home care attendant, and authorized by a licensed physician or an RN (hereafter referred to as the authorizing health care professional):

- \*Assistance with the self-administration of medications in accordance with OAC rule 5160-44-27.
- \*The performance of certain nursing tasks in accordance with OAC rule 5160-44-27 and
- \*Personal care aid tasks as set forth in rule 5160-46-04 or rule 173-39-02.11 of the Administrative Code.

While this service includes personal care aide tasks, it is more involved because of the provision of assistance with self-administration of medication and the performance of certain nursing tasks – tasks that have, until the passage of RC 5111.88-5111.8811 (Am Sub HB 1, 128th General Assembly), and the addition of this service, had to be performed by an RN, or licensed practical nurse at the direction of an RN, as waiver nursing, private duty nursing or home health nursing services.

Home care attendants are non-agency providers. Individuals who receive home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services. A home care attendant shall assist an individual with the self-administration of only the following medication: oral medication; topical medications; subcutaneous injections of routine doses of insulin; programming of a pump used to deliver routine doses of insulin; medication administered via stable, labeled gastrostomy or jejunostomy tubes using pre-programmed pumps; and doses of scheduled II, III, IV, and V drugs only when administered orally or topically.

A home care attendant shall not assist an individual with the performance of any of the following nursing tasks: intravenous (IV) insertion, removal or discontinuation; intramuscular injections; IV medication administration; subcutaneous injections (except for routine doses of insulin as described in the previous paragraph); programming of pumps used to deliver medications, including but not limited to epidural, subcutaneous and IV (and except for routine doses of insulin as described in the previous paragraph); insertion and initiation of infusion therapies; and central line dressing changes.

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

Individuals who receive home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services.

- Individuals cannot receive, and providers cannot bill separately for personal care aide services when personal care aide tasks are performed during a home care attendant service visit.
- A home care attendant who provides home care attendant services to an individual in accordance with the limitations set forth in Sections 5166.30-5166.3010 of the Revised Code, and Rule 5160-44-27 of the Administrative Code, including activities in accordance with the authorizing health care professional's authorization, is not considered to be engaging in the practice of nursing as an RN or an LPN in violation of section 4723.03 of the Revised Code (the Ohio Nurse Practice Act).
- Home Care Attendant Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

**Provider Specifications**

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
		Non-agency home care attendant		

Specify whether the service may be provided by ( <i>check each that applies</i> ):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
<b>Provider Qualifications</b> ( <i>provide the following information for each type of provider</i> ):			
Provider Type:	License ( <i>specify</i> )	Certificate ( <i>specify</i> )	Other Standard ( <i>specify</i> )

<p>Individual</p>		<p>ODA certification as an LTC non-agency provider: OAC 173-39-03 - This rule describes the certification process for community-based long-term care services beginning with the request for the application and concluding with the final description of how ODA issues the certification. OAC 173-39-02. Conditions of Participation for PASSPORT Services. This rule establishes the requirements and scope of responsibility related to service delivery and documentation. OAC 173-39-02.24 Home Care Attendant Service Specifications. This rule establishes the parameters for the type of tasks and describes the timelines and documentation requirements for this service.</p> <p>OR</p> <p>ODM-approved as a provider for the same or similar service;</p>	
-------------------	--	---	--

		OR DODD-certified provider for the same or similar service	
--	--	--	--

<p>Non-agency home care attendant (MyCare)</p>		<p>See other standard.</p> <p>OR</p> <p>ODM-approved as a provider for the same service;</p> <p>OR</p> <p>DODD-certified provider for the same service</p>	<p>ORC Sections 5111.88 to 5111.8811 and OAC Rule 5160-44. Specifically, the provider must supply ODM with evidence to its satisfaction of all of the following:</p> <p>1)The home care attendant either meets the personnel qualifications specified in 42 CFR 484.4 for home health aides, or has successfully completed at least one of the following:</p> <ul style="list-style-type: none"> <li>* A competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code;</li> <li>* A training program approved by ODM that includes training in at least all of the following and provides training equivalent to that approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code or that meets the requirements of 42 CFR 484.36(a), basic home safety, universal precautions for the prevention of disease transmission, consumer-specific personal care aide services and the labeling, counting and storage requirements for schedule medications;</li> </ul> <p>2)Prior to beginning home care attendant services, the home care attendant must have received training and instruction about how to deliver the specific home care attendant services authorized by the individual's authorizing health care professional, and/or the individual or the authorized representative in cooperation with the individual's licensed health care professional.</p> <p>3)Upon request of the individual, individual's authorized representative, or the individual's authorizing health care professional, the home care attendant has performed a successful return demonstration of the home care attendant service to be provided.</p>
--	--	--	--

			<p>4)The home care attendant has obtained a certificate of completion of a course in first aid that is not provided solely through the Internet, includes hands-on training by a certified first aid instructor, and requires the home care attendant to perform a successful return demonstration of what was learned in the course.</p> <p>5)The home care attendant must secure the services of an RN, in agreement with the individual or authorized representative, and participate in a face-to-face visit every ninety days with the individual, authorized representative, and the RN for the purpose of monitoring the individual's health and welfare. During the face-to-face visit, the RN shall serve as a resource for the purpose of answering any questions the home care attendant, individual and/or authorized representative have about individual care needs, medications and other issues. The home care attendant and the RN shall document the activities of the visit in the individual's clinical record. The home care attendant shall also discuss the results of the face-to-face visit with the case manager, and the individual or authorized representative.</p> <p>6)The home care attendant shall complete at least twelve hours of in-service continuing education regarding home care attendant services annually. Continuing education topics include, but are not limited to, individual health and welfare, CPR, patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings and mental health issues.</p> <p>7)The home care attendant shall not provide home care attendant services until the department receives an ODM-approved home care attendant service plan authorization form that contains all of the following:</p>
--	--	--	---

			<p>* Written consent from the individual or the authorized representative allowing the home care attendant to provide home care attendant services;</p> <p>* Written consent from the individual's authorizing health care professional indicating that the home care attendant has demonstrated the ability to furnish the individual's specific home care attendant service to the individual. The consent must include the individual's name and address; a description of the specific nursing task or self-administration of medication that the attendant will assist with (including name, dosage and route of administration of any medications); the times/intervals when the attendant is to assist the individual; the dates on which the attendant is to begin and cease providing assistance; a list of severe adverse reactions that the attendant must report to the individual's health care professional; at least one telephone number at which the attendant can reach the individual's health care professional in an emergency for consultation after contacting emergency personnel; at least one fax number at which the attendant can reach the individual's authorizing health care professional when the schedule drugs are missing or cannot be reconciled; and instructions the attendant must follow when assisting the individual (including instructions for maintaining sterile conditions and for the storage of task-related equipment and supplies). ODM will communicate to the waiver service coordinator that the home care attendant has been authorized by the authorizing health care professional to provide home care attendant services to the individual.</p> <p>ODM Providers: Compliance with OAC Chapters 5160-44, 5160-45, and 5160-46  ODA Providers: Compliance with OAC Chapters 5160-44, 173-39, including 173-39-02.24</p>
--	--	--	--

--	--	--	--

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	Ohio Department of Aging (ODA) ODA's designee	In accordance with OAC 173-39-04.
Non-agency home care attendant (MyCare)	ODM or its designee for ODM-approved providers  The ICDS plan as part of its credentialing and recredentialing processes will verify that the provider has an active Medicaid provider agreement to furnish waiver services. The home care attendant is not enrolled as an approved provider until the information on the ODM-approved home care attendant service plan authorization form has been verified by OMA. A copy of the form is then attached to the provider master file that is accessible to the ICDS plan.	ODM - Verification of Provider qualifications occurs in accordance with OAC 5160-45-06 ODA - Verification of Provider qualifications occurs in accordance with OAC 173-39-04
<b>Service Delivery Method</b>		
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed



**Service Specification**

Service Title: Assisted Living (Assisted Living and My Care)

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

**Service Definition (Scope):**

Waiver participants reside in a setting that provides supervision and staffing to meet planned and unscheduled needs.

The scope of the service includes personal care, supportive services (homemaker and chore), 24 hour on site response capability, social and recreational programming, nonmedical transportation and the coordination of the provision of three meals a day and snacks.

Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management including medication administration, and the delivery of part-time intermittent nursing and skilled nursing up to the maximum allowed in Ohio Administrative Code (OAC) Rule 3701-16-09.1 and when not available through a third party.

The scope of the service does not include 24 hour skilled care, one on one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications or over the counter medications.

Double occupancy of a living unit is only permitted under these circumstances:

- Waiver participant requests the double occupancy at the time of the assessment AND
- there is an existing relationship between the waiver participant and the individual.

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

**As Currently Approved in the MyCare Waiver:**

The service is limited to one unit per calendar day.

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Residential Care Facilities (Both PASSPORT and MyCare)

Specify whether the service may be provided by *(check each that applies):*

<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
--------------------------	----------------------------	--------------------------	-------------------------

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

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
----------------	--------------------------	------------------------------	---------------------------------

<p>Residential Care Facilities (PASSPORT)</p>	<p>Ohio Department of Health Residential Care Facility (RCF) License Ohio Administrative Code 3701-16-01 through 3701-16-18.</p>	<p>Ohio Department of Aging (ODA)  Ohio Administrative Code 173-39-03 ODA Long Term Care Provider Certification  This rule describes the certification process for community-based long-term care service providers beginning with the request for the application by the licensed RCF and concluding with the final description of how ODA issues the certification  OAC 173-39-02 Conditions of Participation  This rule establishes the requirements and scope of responsibility of licensed residential care facility certified to provide the waiver service.  OAC 173-39-02.16 Assisted Living Service Specification  This rule establishes the guidelines for the living unit requirements to</p>	<p>Ohio Department of Medicaid (ODM) Active Medicaid Provider Agreement (OAC 5160-1-17.2)</p>
---	--	--	---

		ensure a homelike, non-institutional setting, service scope, and staff orientation, training and supervision.	
Residential Care Facilities (MyCare)	Ohio Department of Health Residential Care Facility (RCF) License per Ohio Administrative Code rules 3701-16-01 through 3701-16-18.		Providers furnishing services in the ICDS waiver will be required to adhere to the following requirements as outlined in the Ohio Administrative Code.  ODA certified provider: Compliance with OAC chapters 5160-44 and 173-39, including 173-39-02.16.

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency (PASSPORT)	Ohio Department of Aging (ODA) ODA's designee	In accordance with OAC 173-39-04.
Residential Care Facilities (MyCare)	ODA or its designee for ODA-certified providers  The ICDS plan as part of its credentialing and recredentialing processes will verify that the provider has an active Medicaid provider agreement to furnish waiver services.	ODA - Verification of provider qualifications is conducted in accordance with OAC 173-39-04

Service Delivery Method				
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed



**Service Specification**

Service Title: Home Delivered Meal Services

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

Service Definition (Scope):

Home delivered meals" is a meal delivery service based on an individual's need for assistance with activities of daily living and/or instrumental activities of daily living in order to safely prepare meals, or ensure meals are prepared to meet the individual's dietary or specialized nutritional needs as ordered by a licensed professional within his or her scope of practice. The service includes the preparation, packaging, and delivery of a safe and nutritious meal(s) to an individual at his or her home. This may include a single ready-to-eat meal, or multiple single-serving meals that are frozen, vacuum-packed, modified-atmosphere-packed meal, or shelf-stable. Specialized meals include, but are not limited to, specialized diets due medical conditions (i.e. reduced sodium, diabetic diet), or specialized textures, therapeutic or kosher meals.

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

- The service includes no more than two meals per day.
- Planned multiple meal delivery may include meals for up to seven days that are compliant with food storage and safety requirements.
- Authorization of bulk meals, not to exceed two meals per day.

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
	<input type="checkbox"/>		<input type="checkbox"/>	Food preparation agency, home health agency, senior centers, social service agency, churches, hospitals, and caterers
	<input type="checkbox"/>		<input type="checkbox"/>	
	<input type="checkbox"/>		<input type="checkbox"/>	

Specify whether the service may be provided by *(check each that applies)*:

<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
--------------------------	----------------------------	--------------------------	-------------------------

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

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
----------------	--------------------------	------------------------------	---------------------------------

<p><b>Agency</b></p>		<p>ODA certification as an LTC agency provider:</p> <p>OAC 173-39-03 - This rule describes the certification process for community-based long-term care services beginning with the request for the application and concluding with the final description of how ODA issues the certification.</p> <p>OAC 173-39-02. Conditions of Participation for PASSPORT Services. This rule establishes the requirements and scope of responsibility related to service delivery and documentation.</p> <p>OAC 173-39-02.14 – Home Delivered Meal Service Specifications. This rule establishes the parameters for the type of meals and describes the timelines and documentation requirements for this service.</p> <p>In addition, provider must meet all Federal, State and local</p>	<p>Compliance with HCBS settings characteristics (OAC 5160-44-01).  Medicaid provider agreement with ODM (OAC 5160-1-17.2)</p>
----------------------	--	---	--

		regulations for preparation, handling and transport of food; must meet ORC chapter 3117 and OAC chapter 3117-1; must meet Ohio Uniform Food Safety Code; must pass all local health department inspections; and must pass all Ohio Department of Agriculture meat and poultry inspections.	

--	--	--	--

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency provider	Ohio Department of Aging (ODA) ODA's Designee	Verification of provider qualifications occurs in accordance with rule 173-39-04 of the Ohio Administrative Code.

**Service Delivery Method**

<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
---	--------------------------	---	-------------------------------------	------------------



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

### OHIO HOME CARE WAIVER

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. 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).

**Service Specification**

Service Title:      Adult Day Health Center Services

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

Service Definition (Scope):

Adult Day Health Center Services (ADHCS) are regularly scheduled services delivered telephonically or in the home or at an adult day health center to individuals age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that is not be used for other purposes during the provision of ADHCS. The services that the adult day health center may provide include, as appropriate to staffing qualifications: waiver nursing or personal care aide services, recreational and educational activities, and when provided in the home, at least one meal, but no more than two meals, per day that meet the individual's dietary requirements. The services the adult day health center may also make available, as appropriate to staffing qualifications, are skilled therapy services, and transportation of the individual to and from ADHCS.

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

- \*ADHCS are reimbursable at a full-day rate when five or more hours are provided to an individual in a day.
- \*ADHCS are reimbursable at a half-day rate when less than five hours are provided to an individual in a day.
- \*None of the services provided by the adult day health center are reimbursable separately.
- \*ADHCS and the provider of such services must be identified on the person-centered service plan.
- \*ADHCS do not include services performed in excess of what is approved pursuant to the person-centered service plan.
- \*ADHCS do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accredited agency; adult day health centers;

Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
--	--------------------------	----------------------------	--------------------------	-------------------------

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

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Agency			Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
----------------	--------------------------------------	---------------------------

	ODM/Provider Oversight Contractor	Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences)
<b>Service Delivery Method</b>		
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E
	<input checked="" type="checkbox"/>	Provider managed

Service Specification

Service Title: Personal Care Aide Services

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

Service Definition (Scope):

Personal Care Aide Services are services provided to an individual pursuant to his or her person-centered service plan that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. Personal Care Aide Services consist of the following:

\*Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output;

\*General homemaking activities including, but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, washing floors and waste disposal;

\*Paying bills and assisting with personal correspondence as directed by the individual; and

\*Accompanying or transporting the individual to Ohio Home Care Waiver services, medical appointments, other community services, or running errands on behalf of the individual.

Personal Care Aide Services provide needed personal care aide services up to the individual's approved individual budget that are not otherwise available. It is different than state plan home health because its provider pool is not limited to Medicare-certified home health agencies and the scope of tasks that can be provided is much broader.

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

Personal Care Aide Services are intended to complement, not replace, similar services available under the Medicaid State Plan. They do not duplicate coverage provided under the State plan, including EPSDT services. They shall not be used in lieu of the Medicaid State Plan home health benefit when it has been determined the individual meets the eligibility criteria to receive that benefit as defined in Rule 5160-12-01 of the Administrative Code.

They services do not include tasks performed, or services provided as part of home maintenance and chore services included in this waiver.

Personal Care Aide Services shall not be authorized as an alternative when the individual refuses to utilize Medicaid home health benefits they have been determined eligible to receive. In these instances, the CMA is responsible for assisting the individual in assessing the risks associated with their decisions and exploring options for meeting the individual's identified needs.

Personal Care Aide Services and the provider of such services must be identified on the person-centered service plan. Personal Care Aide Services do not include services performed in excess of the number of hours approved pursuant to the person-centered service plan.

If the provider cannot perform IADLs, the provider must notify ODM or the CMA in writing of the service limitations before inclusion on the individual's person-centered service plan.

\*Personal Care Aide Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Non-agency employed personal care aide; or an ODA- or DODD-certified provider of the same or similar service		Medicare-certified home health agency; ACHC-, CHAP- or Joint Commission-accredited agency, or an ODA- or DODD-certified provider of the same or similar service
Specify whether the service may be provided by <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	

<p>Non-agency provider</p>		<p>Certificate of completion within the last 24 months for either a competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio Department of Health in accordance with section 3721.31 of the Revised Code; or the Medicare competency evaluation program for HHAs as specified in 42 CFR 484.36; or another equivalent training program that includes training in the following areas:</p> <ul style="list-style-type: none"> <li>*Personal Care Aide Services;</li> <li>*Basic home safety; and</li> <li>*Universal precautions for the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.</li> </ul> <p>First aid certification.</p>	<p>Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46</p>
----------------------------	--	---	--

		ODA or DODD provider certification	
Agency Provider		Medicare-certified HHA; ACHC-, CHAP- or Joint Commission-accreditation  ODM-approved adult day health center, or ODA or DODD provider certification	Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Non-agency Provider	ODM/Provider Oversight Contractor		Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences)
Agency Provider	ODM/Provider Oversight Contractor		Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences)
Service Delivery Method			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed



Service Specification

Service Title: Home Care Attendant Services

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

Service Definition (Scope):

Home care attendant services include all of the following tasks when provided by an unlicensed home care attendant, and authorized by a licensed physician or a registered nurse (RN) (hereafter referred to as the authorizing health care professional):

- \* Assistance with the self-administration of medications in accordance with OAC rule 5160-44-27;
- \* The performance of certain nursing tasks in accordance with OAC rule 5160-44-27; and
- \* Personal care aide tasks as set forth in OAC rule 5160-46-04.

While this service includes personal care aide tasks, it is more involved because of the provision of assistance with self-administration of medication and the performance of certain nursing tasks - tasks that have, until the passage of RC 5166.30-5166.3010, and the addition of this service, had to be performed by an RN, or licensed practical nurse at the direction of an RN, as waiver nursing, private duty nursing or home health nursing services.

Home care attendants are non-agency providers (i.e., independent contractors) who bill ODM directly for reimbursement for services provided. The service doesn't require a financial management service (FMS) provider, and ODM issues the 1099 directly to the home care attendant. Individuals who receive home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services.

A home care attendant shall assist an individual with the self-administration of only the following medication: oral medications; topical medications; subcutaneous injections of routine doses of insulin; programming of a pump used to deliver routine doses of insulin; medication administered via stable, labeled gastrostomy or jejunostomy tubes using pre-programmed pumps; and doses of schedule II, III, IV and V drugs only when administered orally or topically.

A home care attendant shall not assist an individual with the performance of any of the following nursing tasks: intravenous (IV) insertion, removal or discontinuation; intramuscular injections; IV medication administration; subcutaneous injections (except for routine doses of insulin as described in the previous paragraph); programming of pumps used to deliver medications, including but not limited to epidural, subcutaneous and IV (and except for routine doses of insulin as described in the previous paragraph); insertion and initiation of infusion therapies; and central line dressing changes.

In accordance with OAC rule 5160-45-03, all ODM-administered waiver individuals and their authorized representatives are empowered to have choice and control over the arrangement and provision of the services they receive, and free choice of provider. For the purposes of the Ohio Home Care Waiver, such services include home care attendant services. The individual must be determined through the assessment and service planning processes to have nursing needs that can be safely met through home care attendant services. Adult individuals may designate an authorized representative to act on their behalf. Individuals who are minors must have an authorized representative. The authorized representative must be present and awake during the provision of home care attendant services.

Home care attendant services must be authorized by an authorizing health care professional. ODM must receive an ODM 2389 "Home Care Attendant Medication Authorization Form" and/or an ODM 2390 "Home Care Attendant Skilled Task Authorization Form" that bear the signatures of the individual or authorized representative, home care attendant and the authorizing health care professional. These forms identify the following:

\* The individual's choice of home care attendant and written or electronic consent from the individual or authorized representative allowing the attendant to provide the specific home care attendant services identified during the assessment and service planning processes.

\* Written or electronic assurance from the individual's authorizing health care professional attesting that the individual or authorized representative possesses the skills necessary to:

+ Actively choose the home care attendant service (over skilled nursing services);

+ Actively choose their home care attendant; and

+ Participate in the implementation of the service itself.

\* Written or electronic assurance from the authorizing health care professional that the attendant has demonstrated the ability to furnish the individual-specific home care attendant service to the individual.

\* A description of the specific nursing task or self-administration of medication that the home care attendant will assist the individual with, and instructions the attendant must follow when assisting the individual.

The home care attendant is required to secure the services of an RN, in agreement with the individual or authorized representative, and participate in a face-to-face or electronic visit every ninety days with the individual, authorized representative, and the RN for the purpose of monitoring the individual's health and welfare. The first RN visit shall occur upon the initiation of home care attendant services and the case manager must be present at that time. During the visit, the RN shall serve as a resource for the purpose of answering any questions the home care attendant, individual and/or authorized representative have about individual care needs, medications and other medical issues. The home care attendant and the RN are required to document the activities of the visit in the individual's clinical record, and the home care attendant must discuss the results of the visit with the case manager and the individual and/or authorized representative. The individual or authorized representative may contact the authorizing health care professional at any time. RNs may include, but are not limited to, the individual's authorizing health care professional, or a private physician's office or clinic nurse, etc. It is the provider's responsibility to secure the services of the nurse.

Medication must be maintained in its original container and the attached label must match the dosage and means of administration set forth on the ODM 2389 "Home Care Attendant Medication Authorization Form." In addition, schedule drugs must have warning labels on them, and the attendant is required to count, and recount at least monthly, the medication in the individual's or authorized representative's presence and record the count on a log located in the individual's record. The attendant is required to notify the authorizing health care professional within 24 hours if any medication is missing, or the count cannot be reconciled. Schedule drugs must be stored separately from all other medications and must be secured and locked at all times when not being administered to the individual in order to prevent access by unauthorized individuals.

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

\* Individuals who receive home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services.

\* Individuals cannot receive, and providers cannot bill separately for personal care aide services when personal care aide tasks are performed during a home care attendant service visit.

\* A home care attendant who provides home care attendant services to an individual in accordance with the limitations set forth in Sections 5166.30-5166.3010 of the Revised Code, and Rule 5160-44-27 of the Administrative Code, including activities in accordance with the authorizing health care professional's authorization, is not considered to be engaging in the practice of nursing as an RN or an LPN in violation of section 4723.03 of the Revised Code (the Ohio Nurse Practice Act).

\* Home Care Attendant Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
	Non-agency Home Care Attendant; or an ODA- or DODD-certified provider for same or similar service			
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	

Individual		ODA or DODD provider certification for same or similar service	<p>ORC Sections 5166.30-5166.3010 and OAC Rule 5160-44-27. Specifically, the provider must supply ODM with evidence to its satisfaction of all of the following</p> <p>1)The home care attendant either meets the personnel qualifications specified in 42 CFR 484.4 for home health aides, or has successfully completed at least one of the following:</p> <ul style="list-style-type: none"> <li>* A competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code;</li> <li>* A training program approved by ODM that includes training in at least all of the following and provides training equivalent to that approved or conducted by the Ohio Department of Health under section 3721.31 of the Revised Code or that meets the requirements of 42 CFR 484.36(a), basic home safety, universal precautions for the prevention of disease transmission, individual-specific personal care aide services and the labeling, counting and storage requirements for schedule medications;</li> </ul> <p>2)Prior to beginning home care attendant services, the home care attendant must have received training and instruction about how to deliver the specific home care attendant services authorized by the individual's authorizing health care professional, and/or the individual or the authorized representative in cooperation with the individual's licensed health care professional.</p> <p>3)Upon request of the individual, individual's authorized representative, or the individual's authorizing health care professional, the home care attendant has performed a successful return demonstration of the home care attendant service to be provided.</p>
------------	--	--	---

			<p>4)The home care attendant has obtained a certificate of completion of a course in first aid that is not provided solely through the Internet, includes hands-on training by a certified first aid instructor, and requires the home care attendant to perform a successful return demonstration of what was learned in the course.</p> <p>5)The home care attendant must secure the services of an RN, in agreement with the individual or authorized representative, and participate in a face-to-face visit every ninety days with the individual, authorized representative, and the RN for the purpose of monitoring the individual's health and welfare. During the face-to-face visit, the RN shall serve as a resource for the purpose of answering any questions the home care attendant, individual and/or authorized representative have about individual care needs, medications and other issues. The home care attendant and the RN shall document the activities of the visit in the individual's clinical record. The home care attendant shall also discuss the results of the face-to-face visit with the case manager, and the individual or authorized representative.</p> <p>6)The home care attendant shall complete at least twelve hours of in-service continuing education regarding home care attendant services annually. Continuing education topics include, but are not limited to, individual health and welfare, CPR, patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings and mental health issues.</p> <p>7)The home care attendant shall not provide home care attendant services until the department receives an ODM-approved home care attendant service plan authorization form that contains all of the following:</p>
--	--	--	---

			<p>* Written consent from the individual or the authorized representative allowing the home care attendant to provide home care attendant services;</p> <p>* Written consent from the individual's authorizing health care professional indicating that the home care attendant has demonstrated the ability to furnish the individual-specific home care attendant service to the individual. The consent must include the individual's name and address; a description of the specific nursing task or self-administration of medication that the attendant will assist with (including name, dosage and route of administration of any medications); the times/intervals when the attendant is to assist the individual; the dates on which the attendant is to begin and cease providing assistance; a list of severe adverse reactions that the attendant must report to the individual's health care professional; at least one telephone number at which the attendant can reach the individual's health care professional in an emergency for consultation after contacting emergency personnel; at least one fax number at which the attendant can reach the individual's authorizing health care professional when the schedule drugs are missing or cannot be reconciled; and instructions the attendant must follow when assisting the individual (including instructions for maintaining sterile conditions and for the storage of task-related equipment and supplies).</p> <p>Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46</p>

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	ODM/Provider Oversight Contractor	Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences)

<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

**Service Specification**

**Service Title:** Out-of-Home Respite Services

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

**Service Definition (Scope):**

Out-of-Home Respite Services are services delivered to consumers in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay.

The services the out-of-home respite provider must make available are:

- \*Waiver nursing
- \*Personal care aide services
- \*Three meals per day that meet the individual's dietary requirements.

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

\*The services delivered by an Out-of-Home Respite service provider cannot be reimbursed separately.

\*Out-of-Home Respite Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

**Provider Specifications**

<b>Provider Category(s)</b> <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				ICF-IID, NF, or another setting approved by ODM or certified by the Ohio Department of Aging or the Ohio Department of Developmental Disabilities;

Specify whether the service may be provided by <i>(check each that applies)</i> :	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
---	--------------------------	----------------------------	--------------------------	-------------------------

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

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Agency	ICF-IID that has an active Medicaid provider agreement in accordance with Sections 5124.06 and 5124.07 of the Revised Code, or NF per OAC rules 5160-3-02 and 5160-3-02.3		Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46

<b>Verification of Provider Qualifications</b>				
<b>Provider Type:</b>	<b>Entity Responsible for Verification:</b>		<b>Frequency of Verification</b>	
Agency	ODM/Provider Oversight Contractor		Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigations of Provider Occurrences).	
<b>Service Delivery Method</b>				
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed



Service Specification					
Service Title:	Waiver Nursing				
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>					
Service Definition (Scope):					
Waiver nursing are part-time, intermittent and/or continuous nursing services provided to individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. Waiver nursing services are furnished within the nurse's scope of practice as set forth in Chapter 4723 of the Revised Code (Ohio's Nurse Practice Act) and Administrative Code rules adopted thereunder.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
The service is intended to complement, not replace, similar services available under the Medicaid state plan and EPSDT services.					
Provider Specifications					
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:		<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Non-agency employed RN; non-agency employed LPN; or an ODA- or DODD-certified provider of same or similar service		Medicare-certified HHA, ACHC-, CHAP-accredited agency, and Joint Commission-accredited agency; or an ODA- or DODD-certified provider of same or similar service		
Specify whether the service may be provided by <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian	
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i>					
Provider Type:	License <i>(specify)</i>		Certificate <i>(specify)</i>		Other Standard <i>(specify)</i>
Individual			ODA or DODD provider certification for same or similar service		Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46
Agency			ODA or DODD provider certification for same or similar service		Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46
<b>Verification of Provider Qualifications</b>					
Provider Type:	Entity Responsible for Verification:			Frequency of Verification	

Individual	ODM/Provider Oversight Contractor	Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigations of Provider Occurrences).		
Agency	ODM/Provider Oversight Contractor	Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigations of Provider Occurrences).		
<b>Service Delivery Method</b>				
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed



**Service Specification**

Service Title: Home Delivered Meal Services

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

**Service Definition (Scope):**

Home delivered meals" is a meal delivery service based on an individual's need for assistance with activities of daily living and/or instrumental activities of daily living in order to safely prepare meals, or ensure meals are prepared to meet the individual's dietary or specialized nutritional needs as ordered by a licensed professional within his or her scope of practice. The service includes the preparation, packaging, and delivery of a safe and nutritious meal(s) to an individual at his or her home. This may include a single ready-to-eat meal, or multiple single-serving meals that are frozen, vacuum-packed, modified-atmosphere-packed meal, or shelf-stable. Specialized meals include, but are not limited to, specialized diets due medical conditions (i.e. reduced sodium, diabetic diet), or specialized textures, therapeutic or kosher meals.

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

- The service includes no more than two meals per day.
- Planned multiple meal delivery may include meals for up to seven days that are compliant with food storage and safety requirements.
- Authorization of bulk meals, not to exceed two meals per day.

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	Individual. List types:	Agency. List the types of agencies:
	Non-agency employed provider	Agency, e.g., Meals on Wheels, a food vendor, etc.

Specify whether the service may be provided by *(check each that applies)*:

<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
--------------------------	----------------------------	--------------------------	-------------------------

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

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Non-agency employed provider	Current, valid license or certificate from the local health department		Compliance with OAC Chapters 5160-44, 5160-45 and 5160-46  Providers must meet all Federal, State and local regulations for preparation, handling and transport of food; must meet ORC Chapter 3177 and OAC Chapter 3177-1; must meet Ohio Uniform Food Safety Code; must pass all local health department inspections; and must pass all Ohio Department of Agriculture meat and poultry requirements.

<b>Verification of Provider Qualifications</b>			
<b>Provider Type:</b>	<b>Entity Responsible for Verification:</b>	<b>Frequency of Verification</b>	
Non-agency employed provider	ODM/Provider Oversight Contractor	Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences)	
Agency provider	ODM/Provider Oversight Contractor	Verification is conducted pursuant to the schedule set forth in OAC Rule 5160-45-06 (Structural Reviews of Providers and Investigation of Provider Occurrences)	
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

<sup>i</sup> Numerous changes that the state may want to make 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; (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.