

## Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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:	Case Management
<b>Service Definition (Scope):</b>	
<p>Services that assist participants in gaining access to needed waiver service and other Medicaid State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source. Case Management consists of the following activities:</p> <ol style="list-style-type: none"> <li>a) Complete the initial comprehensive assessment and periodic reassessments to determine the services and supports required by the participant to prevent unnecessary institutionalization ;</li> <li>b) Perform reevaluations of participants' level of care;</li> <li>c) Complete the initial comprehensive service plan and periodic updates to address the participants identified needs;</li> <li>d) Research the availability of non-Medicaid resources needed by an individual to address needs identified through the comprehensive assessment process and assist the individual in gaining access to these resources;</li> <li>e) Assist the individual to gain access to available Medicaid State Plan services necessary to address identified needs;</li> <li>f) Assist the individual to select from available choices, an array of waiver services to address the identified needs and assist the individual to select from the available choice of providers to deliver each of the waiver services;</li> <li>g) Assist the individual to request a fair hearing if choice of waiver services or providers is denied;</li> <li>h) Monitor to assure the provision and quality of services identified in the individual's service plan;</li> <li>i) Support the individual/legal representative/family how to independently obtain access to services when other funding sources are available;</li> <li>j) Monitor on and ongoing basis the individual's health and safety status;</li> <li>k) Coordinate across Medicaid programs to achieve a holistic approach to care;</li> <li>l) Provide case management and transition planning services up to 180 days immediately prior to the date an individual transitions from a nursing facility to the waiver program;</li> <li>m) Provide discharge planning services to an individual disenrolling from the waiver;</li> <li>n) Perform internal quality assurance activities, addressing all performance measures.</li> </ol>	
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>	
<p>Case management services to facilitate transition may be furnished up to 180 days prior to transition and providers may bill for this service effective with the date of the person's entry into the waiver program.</p> <p>Individuals staff providing HCBS waiver case management services cannot also be providers of other types of Medicaid case management services either through the Medicaid State Plan or through the Prepaid Mental Health Plan. Provider entities having the capacity to perform multiple case management functions must assure that the separation between the functions of the entity are clearly separated and their respective responsibilities well defined.</p>	

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Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Area Agencies on Aging
			Division of Services for People with Disabilities
			Independent Living Centers
			Certified Case Management Agencies
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 (specify)	Certificate (specify)	Other Standard (specify)
<b>Area Agencies on Aging</b>	AAA employees with RN and SSW licensure		(a) Recognized Area Agency on Aging entity within the State (b) On Contract with the SMA
<b>Division Services for People with Disabilities</b>	DSPD employees with RN and SSW licensure		(a) Recognized Division of Service for People with Disabilities entity (b) On Contract with the SMA
<b>Prepaid Inpatient Health Plans</b>	PIHP employees with RN and SSW licensure		(a) Recognized Division of Service for People with Disabilities entity (b) On Contract with the SMA (c) Service provided under this waiver are paid to PIHPs on a fee-for-service basis only.
<b>Independent Living Centers</b>	ILC employees with RN and SSW licensure		(a) Independent Living Centers Recognized through the State Office of Rehabilitation (b) On Contract with the SMA
<b>Accredited Case Management Agencies</b>	Case Management Agency employees with RN and SSW licensure		(a) Case Management Agency accredited by DHCF approved organization. (b) On Contract with the SMA
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
<b>Case Management Providers</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>
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

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Service Specification			
<b>Service Title:</b>	<b>Homemaker</b>		
<b>Service Definition (Scope):</b>			
Services consisting 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			
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>			
This service cannot be provided to consumers receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the homemaker services.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Self-directed services providers	Agency. List the types of agencies: Homemaker Agency and Home Health Agency
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 (specify)	Certificate (specify)	Other Standard (specify)
<b>Agency Based - Homemaker</b>	Current Business License		(a) Medicaid provider enrolled to provide Homemaker services (b) Demonstrated ability to perform the tasks ordered by the case management agency
<b>Self-directed services – Homemaker</b>			(a) Medicaid provider enrolled to provide Homemaker services (b) Demonstrated ability to perform the tasks ordered by the case management agency
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
<b>Homemaker Services</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>
Service Delivery Method			
<b>Service Delivery Method</b>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>
		Provider managed	

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(check each that applies):			
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Service Specification			
<b>Service Title:</b>	<b>Adult Day Care (Adult Day Health)</b>		
<b>Service Definition (Scope):</b>			
Services generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).			
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>			
Transportation between the participant's place of residence and the adult day care site is not provided as a component of adult day care services and the cost of this transportation is not included in the rate paid to adult day care providers.			
Provider Specifications			
<b>Provider Category(s)</b> (check one or both):	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:	
		Licensed Adult Day Care Facilities	
<b>Specify whether the service may be provided by</b> (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian	
<b>Provider Qualifications</b> (provide the following information for each type of provider):			
<b>Provider Type:</b>	<b>License (specify)</b>	<b>Certificate (specify)</b>	<b>Other Standard (specify)</b>
Licensed Adult Day Care Facilities	Adult Day Care Center: UAC R501-13-1-13 or R432-150-6 or R 432-270-29		Medicaid Provider enrolled to provide adult day care services.
Verification of Provider Qualifications			
<b>Provider Type:</b>	<b>Entity Responsible for Verification:</b>		<b>Frequency of Verification</b>
<b>Adult Day Care</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>
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			
<b>Service Title:</b>	<b>Habilitation Services</b>		

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<b>Service Definition (Scope):</b>			
<p>Habilitation Services are services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.</p> <p>Specific services include the following:</p> <ol style="list-style-type: none"> <li>restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);</li> <li>social skills training in appropriate use of community services;</li> <li>development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion).</li> </ol>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
<p>The following are specifically excluded from payment for habilitation services:</p> <ol style="list-style-type: none"> <li>vocational services,</li> <li>prevocational services,</li> <li>supported employment services, and</li> <li>room and board.</li> </ol>			
<b>Provider Specifications</b>			
Provider Category(s) (check one or both):	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:	
		Habilitation Providers	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian	
<b>Provider Qualifications</b> (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
<b>Habilitation Services</b>	R432-700 , Current Business License		Demonstrated ability to performs the tasks ordered on behalf of the waiver participant  Medicaid Providers enrolled to provide habilitation services.
<b>Verification of Provider Qualifications</b>			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
<b>Habilitation Providers</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>	<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>	
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b>	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed	
<b>Service Specification</b>			
<b>Service Title:</b>	<b>Respite Care Services</b>		

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**Service Definition (Scope):**

Care provided to give relief to, or during the absence of, the normal care giver. Respite care may include hourly, daily and overnight support and may be provided in the individual's place of residence, a facility approved by the State which is not a private residence, or in the private residence of the respite care provider.

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

Payments for respite services are not made for room and board except when provided as a part of respite care in a setting, approved by the State that is not the individual's private residence. In the case of respite care services that are rendered out of the consumer's private residence in a setting approved by the State, this service will be billed under a specific "Respite Care-Out of the home/Room and Board included" billing code.  
 All instances in which respite care services are delivered for a period of six hours or more within a day shall be billed using a daily rate rather than hourly rates for this service.  
 Each Residential Respite Care episode is limited to a period of 13 consecutive days or less not counting the day of discharge. The number of Residential Respite Care episodes may not exceed three in any calendar year.

**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:
	Self-Directed Services Employees	Home Health Agencies
		Licensed Health Care Facilities
		Licensed Residential Treatment Facilities

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
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**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>
<b>Home Health Agency</b>	R432-700		Demonstrated ability to performs the tasks ordered on behalf of the waiver participant  All providers: Medicaid provider enrolled to provide respite services.
<b>Adult Day Care</b>	R501-13-1		
<b>Nursing Facilities</b>	R432-150		
<b>Assisted Living Facilities</b>	R432-270		
<b>Residential Treatment Facility</b>	R501-19-13		

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
<b>Respite Care Services</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>	<b>Upon initial enrollment and annual sampling of waiver</b>

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		<b>providers thereafter.</b>	
<b>Service Delivery Method</b>			
<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

<b>Service Specification</b>			
<b>Service Title:</b>	<b>Adult Residential Services</b>		
<b>Service Definition (Scope):</b>			
<p>Personal care and supportive services (homemaker, chore, attendant services, meal preparation), including companion services, medication oversight (to the extent permitted under State law), including 24 hour on-site response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services provided by third parties must be coordinated with the residential services provider.</p> <p>Service and support include 24 hour on-site response capability or other alternative emergency response arrangements determined appropriate to meet scheduled or predictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting.</p> <p>Nursing and skilled therapy services are incidental, rather than integral to the provision of adult residential services.</p> <p>Types of Adult Residential Services Providers:</p> <ul style="list-style-type: none"> <li>a) Adult host homes</li> <li>b) Assisted living facilities</li> <li>c) Licensed community residential care facilities</li> <li>d) Certified community residential care facilities*</li> </ul> <p>* Certified community residential care facilities are those in which 3 or fewer individuals reside.</p>			
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>			
<p>Separate payment is not made for homemaker services, chore services, or companion services furnished to a participant receiving adult residential services, since these services are integral to and inherent in the provision of adult residential services.</p> <p>Payment is not made for 24-hour skilled care or supervision. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for adult residential services is described in Appendix I.</p>			
<b>Provider Specifications</b>			
<b>Provider Category(s)</b>	<input type="checkbox"/>	<b>Individual. List types:</b>	<input checked="" type="checkbox"/> <b>Agency. List the types of agencies:</b>
			Adult Host Homes, Assisted Living Facilities,

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(check one or both):		Licensed community residential care facilities, Certified community residential care facilities.		
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
<b>Provider Qualifications</b> (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
<b>Adult Host Home Certified Community Residential Care Facilities</b>	Current Business License		All Providers: Medicaid provider enrolled to provide adult residential services	
<b>Licensed Community Residential Care Facilities</b>	Current Business License R432-270 R432-200 R432-300 or R501-19			
<b>Verification of Provider Qualifications</b>				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
<b>Adult Residential Services</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>	
<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
<b>Service Specification</b>				
<b>Service Title:</b>	<b>Attendant Care Services</b>			
<b>Service Definition (Scope):</b>				
Supportive and health-related services, specific to the needs of a participant with disabilities. Supportive services are those that reinforce an individual's strengths, while substituting or compensating for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant services incorporate and respond to the participant's preferences and priorities. Health-related services may include skilled or nursing care to the extent permitted by State law. Health related services are provided and supervised as required under State law, or the terms under which the specific attendant worker has been certified to furnish the service. Documentation of any delegation or assignment of nursing tasks or supervision will be maintained in the participant's service plan.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
This service cannot be provided to participants receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the attendant care services.				
<b>Provider Specifications</b>				

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Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individual employees hired under the self-administered services method		Home Health Agency Personal Care Services Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
<b>Provider Qualifications</b> (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
<b>Attendant Care Services</b>	R432-700		All providers: Medicaid providers enrolled to provide attendant care services	
<b>Verification of Provider Qualifications</b>				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
<b>Attendant Care Services</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>	
<b>Service Delivery Method</b>				
<b>Service Delivery Method</b> (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
<b>Service Specification</b>				
<b>Service Title:</b>	<b>Caregiver Training</b>			
<b>Service Definition (Scope):</b>				
Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship, or support to a person served on the waiver. Individuals who are employed to support the participant may not receive this service. Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. All training the individuals who provide unpaid support to the participant must be included in the participant's service plan. The service covers the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the service plan.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
No limits				
<b>Provider Specifications</b>				
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Formal training suppliers; home health agencies

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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> )	
As authorized by State law for specific training category	R156 or R432 as applicable (providers of training in categories requiring license under State law) <b>Or</b> Current business license (formal training suppliers)		(a) Demonstrated ability to perform the tasks ordered by the case management agency. (b) Medicaid provider enrolled to provide caregiver training	
<b>Verification of Provider Qualifications</b>				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
All Caregiver Training Suppliers	Division of Health Care Financing, Long Term Care Bureau		Upon initial enrollment and annual sampling of waiver providers thereafter.	
<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
<b>Service Title:</b>	<b>Chore Services</b>			
<b>Service Definition (Scope):</b>				
Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access or egress.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other caregiver, landlord, community/volunteer agency, or third party payer is capable or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service. Additionally this service is not available concurrent with any other waiver service in which the tasks performed are duplicative of chore services.				
<b>Provider Specifications</b>				
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:
	Individual employees hired under the self-administered services method		Chore service providers	
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

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<b>Provider Qualifications</b> (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
<b>Chore Services</b>	Current Business License		(a) Medicaid provider enrolled to provide chore services (b) demonstrated ability to perform the tasks ordered by case management provider
<b>Verification of Provider Qualifications</b>			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
<b>Chore Services</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed
<b>Service Title:</b>	<b>Environmental Accessibility Adaptations</b> a) Home Modifications b) Vehicle Modifications		
<b>Service Definition (Scope):</b>			
<p>Equipment and/or physical adaptations to the individual's residence or vehicle which are necessary to assure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the home and in the community, and without which, the individual would require institutionalization. The equipment/adaptations are identified in the individual's service plan and the model and type of equipment are specified by a qualified individual. The adaptations may include purchase, installation, and repairs. Other adaptation and repairs may be approved on a case by case basis as technology changes or as an individual's physical or environmental needs change. All services shall be provided in accordance with applicable State or local building codes and may include the following:</p> <ul style="list-style-type: none"> <li>- Home <ul style="list-style-type: none"> <li>Authorized equipment/adaptations such as: <ol style="list-style-type: none"> <li>a. Ramps</li> <li>b. Grab bars</li> <li>c. Widening of doorways/hallways</li> <li>d. Modifications of bathroom/kitchen facilities</li> <li>e. Modification of electric and plumbing systems which are necessary to accommodate the medical equipment, care and supplies that are necessary for the welfare of the individual.</li> </ol> </li> </ul> </li> <li>- Vehicle <ul style="list-style-type: none"> <li>Authorized vehicle adaptations such as: <ol style="list-style-type: none"> <li>1. lifts</li> <li>2. door modifications</li> <li>3. steering/braking/accelerating/shifting modifications</li> <li>4. seating modifications</li> <li>5. safety/security modifications</li> </ol> </li> </ul> </li> </ul> <p>The following are specifically excluded:</p> <ol style="list-style-type: none"> <li>a. Adaptations or improvements to the home or vehicle that are of general utility, and are not of direct</li> </ol>			

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- medical or remedial benefit to the individual;
- b. Adaptations that add to the total square footage of the home;
- c. Purchase or lease of a vehicle; and
- d. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

Service Limit: The maximum allowable cost per environmental accessibility adaptation is \$2,000.00. At the point a waiver participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

**Provider Specifications**

Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
			Environmental adaptations suppliers	

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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**Provider Qualifications** (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Environmental Adaptations Supplier	Current business license <b>and</b> Contractor's license when applicable		All providers: Demonstrated ability to perform the tasks ordered by the case management agency.

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Environmental Adaptations Supplier	<b>Division of Health Care Financing, Long Term Care Bureau</b>	<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>

**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
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**Service Title:** Home Delivered Meals

**Service Definition (Scope):**

Home Delivered Supplemental Meal provides a nutritionally sound and satisfying meal to individuals who are unable to prepare their own meals and who do not have a responsible party or volunteer caregiver available to prepare their meals for them.  
 Elements of Home Delivered Supplemental Meal Category: The Home Delivered Supplemental Meal category

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includes a prepared meal component and a nutritional supplement component. Either component constitutes a supplemental meal when provided in an amount that meets the nutritional needs of the individual. Each supplemental meal provided shall provide a minimum of 33 1/3 percent of the daily Recommended Dietary Allowances (RDA) and Dietary Reference Intake (DRI) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, Institute of Medicine and Mathematica Policy Research, Incorporated.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).				
<b>Provider Specifications</b>				
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:
			Restaurants, Health care facilities, Local Public agencies	
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>	
<b>Home Delivered Meals</b>	Current business license		Compliance with UAC R70-530 All programs: Medicaid providers enrolled to provide home delivered meals	
<b>Verification of Provider Qualifications</b>				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
<b>Home Delivered Meals</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>	
<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
<b>Service Title:</b>	<b>Institutional Transition Services</b>			
<b>Service Definition (Scope):</b>				
Provision of essential household items and services needed to establish basic living arrangements in a community setting that enable the individual to establish and maintain health and safety. Essential household items include basic furnishings, kitchen and bathroom equipment and goods, communication devices, and security devices. This service also includes one-time non-refundable fees to establish utility services and other services essential to the operation of the residence.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Reimbursement for the cost of rent or food is not a covered expense under this service. Reimbursable items are limited to only those household items that are essential. Reimbursement for the cost of refundable fees or deposits is not a covered expense under this service.				

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Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Suppliers of household furnishings, equipment and supplies.	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
<b>Provider Qualifications</b> (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
<b>Institutional Transition Suppliers</b>	Current business license if applicable		
<b>Verification of Provider Qualifications</b>			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
<b>Institutional Transition Suppliers</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>
<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
<b>Service Title:</b>	<b>Medication Administration Assistance Services</b>		
<b>Service Definition (Scope):</b>			
<ul style="list-style-type: none"> <li>- Medication Reminder System (Not Face-To-Face) Medication Reminder System provides a medication reminder by a third party entity or individual that is not the clinician responsible for prescribing and/or clinically managing the individual, not the entity responsible for the administration of medication, and not the entity responsible for the provision of nursing or personal care, attendant care, or companion care services. Services involve non face-to-face medication reminder techniques (e.g. phone calls, telecommunication devices, medication dispenser devices with electronic alarms which alert the individual and a central response center staffed with qualified individuals, etc.)</li> <li>- Medication Set-Up Services of an individual authorized by State law to set-up medications in containers that facilitate safe and effective self-administration when individual dose bubbling packaging by a pharmacy is not available and assistance with self-administration is not covered as an element of another waiver service.</li> </ul>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
This service is not available to individuals eligible to receive the service through the Medicaid State Plan or other funding source.			
Provider Specifications			
Provider	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:

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Category(s) (check one or both):		Medication reminder equipment suppliers, Home health agencies	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
<b>Provider Qualifications</b> (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
<b>Medication Administration Assistance</b>	UAC R156-31b (medication set-up)  Current business license as applicable (reminder devices)		Medicaid provider enrolled to provide medication administration assistance.
<b>Verification of Provider Qualifications</b>			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
<b>Medication Administration Assistance</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>
<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
<b>Service Title:</b>	<b>Personal Emergency Response System</b>		
<b>Service Definition (Scope):</b>			
An electronic device that enables an individual to secure help in an emergency through a connection to a signal response center that is staffed by trained professionals on a 24 hour per day, seven days a week basis.			
<ul style="list-style-type: none"> <li>- Personal Emergency Response Systems (PERS) Response Center Service Provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency.</li> <li>- Personal Emergency Response System (PERS) Purchase, Rental &amp; Repair Provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center.</li> <li>- Personal Emergency Response System (PERS) Installation, Testing &amp; Removal Provides installation, testing, and removal of the PERS electronic device by trained personnel.</li> </ul>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
No Limits			
<b>Provider Specifications</b>			

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Provider Category(s) (check one or both):	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies: Personal Emergency Response System supplier; Home Health Agency; Other response centers	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian	
<b>Provider Qualifications</b> (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Emergency Response System Supplier	Current business license, <b>and</b>		Equipment suppliers: FCC registration of equipment placed in the individual's home.
Personal Emergency Response System Installer	Current business license, <b>and</b>		Installers: Demonstrated ability to properly install and test specific equipment being handled.
Personal Emergency Response Center	Current business license, <b>and</b>		Response Centers: 24 hour per day operation, 7 days per week.
			All providers: Medicaid provider enrolled to provide personal emergency response system services.
<b>Verification of Provider Qualifications</b>			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Emergency Response System	Division of Health Care Financing, Long Term Care Bureau		Upon initial enrollment and annual sampling of waiver providers thereafter.
<b>Service Delivery Method</b>			
Service Delivery Method (check each that applies):	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed	
Service Title:	<b>Specialized Medical Equipment and Supplies</b>		
<b>Service Definition (Scope):</b>			
Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service covers items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Coverage includes the costs of			

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maintenance and upkeep of equipment, training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply, and the performance of assessments to identify the type of equipment needed by the participant.			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Medical equipment and supply suppliers
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 (specify)	Certificate (specify)	Other Standard (specify)
Medical equipment and supply suppliers	Current business license if applicable		Medicaid provider enrolled to provide medical equipment and supplies.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Medical equipment and supply suppliers	Division of Health Care Financing, Long Term Care Bureau		Upon initial enrollment and annual sampling of waiver providers thereafter.
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed
Service Title:	Transportation - Non-Medical		
Service Definition (Scope):			
Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Non-Medical transportation is not available for the provision of transportation to medical appointments.			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Public transit agencies, taxi companies, private transportation companies.

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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> )	
<b>Non-Medical Transportation</b>	Licensed public transportation carrier or Individual driver's license		All providers: (a) Registered and insured vehicle: UCA 53-3-202, UCA 41-12s-301 to 412 (b) Medicaid provider enrolled to provide non-medical transportation services.	
<b>Verification of Provider Qualifications</b>				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
<b>Non-Medical Transportation Providers</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>	
<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
<b>Service Title:</b>	<b>Personal Budget Assistance</b>			
<b>Service Definition (Scope):</b>				
Personal budget assistance provides assistance with financial matters, fiscal training, supervision of financial resources, savings, retirement, earnings and funds monitoring, monthly check writing, bank reconciliation, budget management, tax and fiscal record keeping and filing, and fiscal interaction on behalf of the individual.				
The purpose of this service is to offer opportunities for waiver participants to increase their ability to provide for their own basic needs, increase their ability to cope with day to day living, maintain more stability in their lives and maintain the greatest degree of independence possible, by providing timely financial management assistance to waiver participants in the least restrictive setting, for those individuals who have no close family or friends willing to take on the task of assisting them with their finances.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
The Personal Budget Assistance provider must assist the waiver participant in reviewing their finances/budget at least monthly, must maintain documentation of this review and must submit the budget review documentation to the to the Case Management Agency for review on a monthly basis.				
<b>Provider Specifications</b>				
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:
				Personal Budget Assistance Providers
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

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<b>Provider Qualifications</b> (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
<b>Personal Budget Assistance</b>	Current Business License		Medicaid provider enrolled to provide personal budget assistance. Demonstrated ability to perform task.
<b>Verification of Provider Qualifications</b>			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
<b>Personal Budget Assistance</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>
<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
<b>Service Title:</b>	<b>Assistive Technology Devices</b>		
<b>Service Definition (Scope):</b>			
<p>This service under the waiver differs in nature, scope, supervision arrangements, or provider from services in the State plan. Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes--</p> <p>(A) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;</p> <p>(B) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;</p> <p>(C) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;</p> <p>(D) Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;</p> <p>(E) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and</p> <p>(F) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.</p>			
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>			
<p>Service Limit: The maximum allowable cost per assistive technology device is \$2,000.00. At the point a waiver participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.</p> <p>Therapies that are not directly related to instructing the participant on the use or selection of an assistive device</p>			

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are not covered under 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:
			Assistive technology device supplier	

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
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**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>
<b>Assistive Technology Device Supplier</b>	Current Business License		Medicaid provider enrolled to provide assistive technology device supplier

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
<b>Assistive Technology Device Supplier</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>	<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>

**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
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**Service Title:** **Specialized Behavioral Health Services**

**Service Definition (Scope):**

This waiver service is designed specifically to address complex needs of waiver enrollees who demonstrate severe, persistent behavior problems related to organic brain diseases, acquired brain injuries, dementia and dementia-related conditions, and other non-psychiatric factors, and who require levels of service that are not otherwise available through the Medicaid State plan or Prepaid Mental Health Program (PMHP). This service is above and beyond the services provided by the State plan and not duplicative in nature.

The service provides educational procedures and techniques that are designed to decrease problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live as independently as possible in their communities. Interventions are based upon the principles of applied behavior analysis and focus on positive behavior supports. Behavior consultants provide individual behavior consultation to families and/or staff who support individuals with behavioral problems that may be complicated by medical or other factors. Problems addressed by behavior consultants are identified as serious, but have not been judged to be treatment resistant or refractory. Consultation shall include designing and training the family and/or support staff on a behavior support plan developed specifically for the person being served. Services are to be provided in the person's residence or other naturally occurring environment in the community. This service is consultative in nature and does not include the provision of any direct services to consumers.

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

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These services are available to individuals whose severe, persistent behaviors have been documented during the comprehensive needs assessment process and have been determined to be problems related to organic brain diseases, acquired brain injuries, dementia and dementia-related conditions, and other non-psychiatric factors.

**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:
			Specialized Behavioral Health Services	
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>
<b>Specialized Behavioral Health Services</b>	UAC Title R156; and R501 as applicable		(a) Board Certified Associate Behavior Analysts (BCABA); or proof of achievement of a post-graduate degree of at least a Masters' in a behaviorally-related field as well as experience of at least one year working in the field of mental retardation or other related conditions; or (b) Completion of a training course in positive behavioral supports approved by the SMA and the successful completion of a learning assessment at the conclusion of the course. And All Providers: (c) Medicaid provider enrolled to provide specialized behavioral health services

**Verification of Provider Qualifications**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
<b>Specialized Behavioral Health Services</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>	<b>Upon initial enrollment and annual sampling if waiver providers thereafter.</b>

**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
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**Service Title: Supportive Maintenance (Home Health Aide) Services**

**Service Definition (Scope):**

Services defined in 42 CFR 440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from home

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health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Supportive maintenance services will only be ordered after full utilization of available State Plan home health services by the participant.			
<b>Provider Specifications</b>			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Home Health Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
<b>Provider Qualifications</b> (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
<b>Supportive Maintenance Services</b>	Home Health Agency: UAC R432-700	Certified by the LTCB as an authorized provider of services and supports.	Under State contract with LTCB as an authorized provider of services and supports.
<b>Verification of Provider Qualifications</b>			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
<b>Supportive Maintenance Services</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>		<b>Upon initial enrollment and annual sampling of waiver providers thereafter.</b>
<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
<b>Service Title:</b>	<b>Consumer Preparation Services</b>		
<b>Service Definition (Scope):</b>			
<p>Services that assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the service plan. This service does not duplicate other waiver services, including case management.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			

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This service is limited to participants who direct some or all of their waiver services or are considering directing some or all of their waiver services.			
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:	Independent Living 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 <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>
<b>Consumer Preparation Services</b>	Have entered into a Medicaid Provider Agreement with the Department of Health.  Current Business License	Certified by the LTCB as an authorized provider of services and supports.	<ol style="list-style-type: none"> <li>1) Under State contract with LTCB as an authorized provider of services and supports.</li> <li>2) Must complete a training course approved by the Long Term Care Bureau, State Medicaid Agency, and must demonstrate competency in related topical area(s) of: <ol style="list-style-type: none"> <li>a) Self-determination</li> <li>b) Natural supports</li> <li>c) Instruction and/or consultation with families/siblings on: <ol style="list-style-type: none"> <li>i) Assisting self sufficiency</li> <li>ii) Safety</li> </ol> </li> </ol> </li> <li>3) Must be a professional with a bachelor's degree in social or behavioral sciences or a mental health professional with a master's degree in social or behavioral sciences.</li> </ol>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
<b>Consumer Preparation Services</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>	<b>Upon initial enrollment and annual sampling if waiver providers thereafter.</b>	
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	
<b>Service Title:</b>	<b>Financial Management Services</b>		
<b>Service Definition (Scope):</b>			

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Financial Management Services is offered in support of the self-administered services delivery option. Services rendered under this definition include those to facilitate the employment of personal attendants or assistants by the individual or designated representative including:

- Provider qualification verification;
- Employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports;
- Medicaid claims processing and reimbursement distribution, and
- Providing monthly accounting and expense reports to the consumer.

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

Service is provided to those utilizing Self Administered Services

**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:
				Licensed Public Accounting Agency

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

	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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**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>
<b>Financial Management Services</b>	Certified Public Accountant Sec 58-26A, UCA And R 156-26A, UAC	Certified by the LTCB as an authorized provider of services and supports.	<ul style="list-style-type: none"> <li>Under State contract with LTCB as an authorized provider of services and supports.</li> <li>Comply with all applicable State and Local licensing, accrediting, and certification requirements.</li> <li>Understand the laws, rules and conditions that accompany the use of State and local resources and Medicaid resources.</li> <li>Utilize accounting systems that operate effectively on a large scale as well as track individual budgets.</li> <li>Utilize a claims processing system acceptable to the Utah State Medicaid Agency.</li> <li>Establish time lines for payments that meet individual needs within DOL standards.</li> <li>Generate service management, and statistical information and reports as required by the Medicaid program.</li> </ul>

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			<ul style="list-style-type: none"> <li>• Develop systems that are flexible in meeting the changing circumstances of the Medicaid program.</li> <li>• Provide needed training and technical assistance to clients, their representatives, and others.</li> <li>• Document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file.</li> <li>• Act on behalf of the person receiving supports and services for the purpose of payroll reporting.</li> <li>• Develop and implement an effective payroll system that addresses all related tax obligations.</li> <li>• Make related payments as approved in the person’s budget, authorized by the case management agency.</li> <li>• Generate payroll checks in a timely and accurate manner and in compliance with all federal and state regulations pertaining to “domestic service” workers.</li> <li>• Conduct background checks as required and maintain results in employee file.</li> <li>• Process all employment records.</li> <li>• Obtain authorization to represent the individual/person receiving supports.</li> <li>• Prepare and distribute an application package of information that is clear and easy for the individuals hiring their own staff to understand and follow.</li> <li>• Establish and maintain a record for each employee and process employee employment application package and documentation.</li> <li>• Utilize and accounting information system to invoice and receive Medicaid reimbursement funds.</li> <li>• Utilize and accounting and information system to track and report the distribution of Medicaid reimbursement funds.</li> </ul>
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			<ul style="list-style-type: none"> <li>• Generate a detailed Medicaid reimbursement funds distribution report to the individual Medicaid recipient or representative semi-annually.</li> <li>• Withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with federal IRS and DOL, and state rules.</li> <li>• Generate and distribute IRS W-2's. Wage and Tax Statements and related documentation annually to all support workers who meet the statutory threshold earnings amounts during the tax year by January 31<sup>st</sup>.</li> <li>• File and deposit federal and state income taxes in accordance with federal IRS and state rules and regulations.</li> <li>• Assure that employees are paid established unit rates in accordance with the federal and state Department of Labor Fair Labor Standards Act (FLSA)</li> <li>• Process all judgments, garnishments, tax levies or any related holds on an employee's funds as may be required by local, state or federal laws.</li> <li>• Distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative.</li> <li>• Prepare employee payroll checks, at least monthly, sending them directly to the employees.</li> <li>• Keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required federal and state filings and the activities related to being a Fiscal/Employer Agent.</li> <li>• Establish a customer service mechanism in order to respond to calls from individuals or their representative employers and workers regarding issues such as withholding and net payments, lost or late checks, reports and other documentation.</li> <li>• Customer service representatives are able to communicate effectively in</li> </ul>
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			<p>English and Spanish by voice and TTY with people who have a variety of disabilities.</p> <ul style="list-style-type: none"> <li>• Have a Disaster Recovery Plan for restoring software and master files and hardware backup if management information systems are disabled so that payroll and invoice payment systems remain intact.</li> <li>• Regularly file and perform accounting auditing to ensure system accuracy and compliance with general accounting practice.</li> </ul>
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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
<b>Financial Management Services</b>	<b>Division of Health Care Financing, Long Term Care Bureau</b>	<b>Upon initial enrollment and annual sampling if waiver providers thereafter.</b>
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

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