SCLARC:

Purchase of Service Funding Standards

DDS Approved 10/18/2010

TABLE OF CONTENTS

INTRODUCTION

Table of Contents

Table of Contents

PHILOSOPHY / INTRODUCTION

2500 Philosophy/Introduction

South Central Los Angeles Regional Center, Inc. (SCLARC), operating under contract with the State Department of Developmental Services (DDS), recognizes its responsibility to assure that all consumers receive services and supports or special adaptations of generic services and supports to do as follows:

1. Prevent developmental disabilities.

2. Ensure that all persons suspected of having a developmental disability receive diagnostic and evaluation services.

3. Protect the consumer's health and safety, and

4. Promote the achievement and maintenance of independent and productive lives.

Consideration must also be given to the ordinary care, support and supervision that a family must provide to a child of the same age without a disability and to cost-effectiveness of the services and supports identified to meet the consumer's needs.

Several changes were made to the Lanterman Act through a Trailer Bill that now prohibits the South Central Los Angeles Regional Center from funding for certain services. The Trailer Bill Language (AB 9, Statutes of 2009) was enacted on July 28, 2009.

Welfare and Institutional Code (WIC) Section 4659 (c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services (CHAMPUS), private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009.

Services/supports are purchased only when it is determined that such services/supports will best accomplish all or any part of a consumer's

Person Centered Individual Program Plan (IPP) or Individual Family Service Plan (IFSP) and is not available in the community. All eligible consumers will receive these services and supports identified as needed in their individual program plans. Such services/supports should maximize the consumer's opportunities and choices for living, working, learning and recreating in the community. Renewal of purchase authorizations shall be contingent upon reasonable progress in achieving the objectives in the IPP/IFSP as well as consumer satisfaction and choices made by consumers, their families and circles of support and the availability of natural supports.

SCLARC will only purchase services that address the needs or problems associated with the consumer's developmental disability. The needs of the consumer's family may be met coincidentally, but will not be funded directly, except as necessary to maintain a child at home.

According to WIC Section 4648 (a) (15), SCLARC cannot purchase experimental treatments, therapeutic services or devices that have not been clinically determined or scientifically proven to be effective and safe or for which risks and complications are unknown.

In order to remain consistent with current law the term "services" will also include support. For clarification, there are two different kinds of support, i.e. formal and informal support. Formal support refers to paid services and informal support refers to non-purchased or generic services.

Pursuant to WIC Section 4646, decisions regarding the consumer's goals, objectives, services and supports that will be purchased by SCLARC will be made by an agreement between one or more SCLARC representatives including the Service Coordinator and the consumer, and/or the consumer's parent/s or authorized representative at the IPP/IFSP meeting. If an agreement cannot be reached at the IPP/IFSP meeting, another meeting must be held within 15 days or later with the consent of the consumer or his or her representative. If the consumer or, when appropriate, his or her parents, legal guardian, or conservator, do not agree with all components of the IPP/IFSP, they can indicate that disagreement in the plan or IPP/IFSP Agreement. They will then receive a written notice of the fair hearing rights as required by WIC Section 4710 or the complaint/due process rights for children under 3 as required by CCR, Title 17 § 52170; and California Early Intervention Services Government Code § 95000 et seq. Disagreement with specific IPP/IFSP components shall not prohibit implementation of services and supports agreed to by the consumer or his or her authorized representative.

Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, WIC Section 4648(a)(6)(D) requires that the

IPP/IFSP planning team review the cost of providing services or supports of comparable quality by different providers and to choose the least costly available provider, including transportation, who is able to accomplish all or part of the consumer's IPP consistent with the particular needs of the consumer and family as identified in the IPP. In determining the least costly provider, the availability of federal financial participation shall be considered. The consumer is not required to use the least costly provider if it will result in the consumer moving from an existing provider of services or supports to a more restrictive or less integrated services or supports.

The person centered IPP and the IFSP must specify the start dates for all services and supports and shall contain timelines for actions necessary to begin services and supports, including generic services. W&I §4646.5 (4)

It should also be noted that WIC Section 4784 of the Welfare and Institutions Code (Parental Fee Program) was amended. The law now states the following:

- DDS to establish, annually review, and adjust as needed, a schedule of parental fees for services received through the regional centers (24- hour out-of-home care for minors)
- Parents with income below the current Federal poverty level will not be assessed a fee
- Fee increase for children currently in an out-of-home placement will be implemented over the next three years, with one-third of the increase added on July 1, 2009, one-third of the increase added on July 1, 2010, and the final third added to the fee on July 1, 2011.
- Parent will pay the full updated fee amount for consumers placed after July 1, 2009.

Prevention's Transfers to other Regional Centers:

Prior to transfer, the Prevention Service Coordinator shall include in the case record, all parent contact information and available records including any evaluations and Prevention Program Plan (PPP). Funds will not be transferred between Regional Centers for the Prevention Program consumers.

2510 Purchase of Service Exception Policy

The purpose of our purchase of service manual is to provide guidelines for the use of Regional Center funds. We acknowledge that each consumer is distinct and it would not be possible to anticipate the supports and services needed for every individual given the complex needs of our service area. Therefore, for requests which are outside of the boundaries

of these guidelines, exceptions may be considered based on the specific needs of an individual. The unique circumstances of each case will be considered. These requests for exceptions will be reviewed by the Compliance Review Committee and the Executive Director or his designee.

2520 Service Priority Guidelines

Through the Individualized Program Plan (IPP) process a consumer receives, as an entitlement, services to enable him/her to live a more independent and productive life in the community. As long as funds remain, the right to services consistent with the purposes of the W&I code must be implemented in full. If a shortfall occurs, then DDS may seek relief from the Legislature. [Association of Retarded Citizens – California v. DDS (1985) 38 Cal.3d 384].

2530 Standards For Purchase of Services/Supports

In keeping with regulations regarding the purchase of services/supports for consumers, SCLARC has developed the following Funding Standards for staff to follow in determining the appropriateness of funding requests with the IPP/IFSP process.

2531 Purchase of Services (P. O. S.) Request Approval Process

Decisions regarding appropriate services for individual consumers are made during the IPP/IFSP process pursuant to Welfare and Institutions Code §4646, ***§4646.4*** & §4646.5. Documentation of those services, in the form of a Purchase of Service Request, is reviewed by the Program Manager and subsequently by the Compliance Review Committee, for correction of any errors, prior to being forwarded to the Fiscal Department for processing.

2540 Emergency Services/Supports

I. Definition

South Central Los Angeles Regional Center (SCLARC) recognizes that consumer-related emergencies which require immediate response can occur at any time.

The purpose of this Emergency Services category is to avoid the delays inherent in the routine requirement of authorizing services in advance of the provision of services/supports. When this emergency procedure is used, the services/ supports can be initiated immediately upon verbal request.

This P.O.S. Standard is intended to address only true "Emergency" situations.

An emergency is defined as an unanticipated situation which, without immediate intervention of a regional center purchase of services/supports, would present an imminent danger with measurable long-term consequences to the physical or psychological health or safety of our consumer.

II. Criteria for Referral

If a situation as defined above occurs during normal working hours, an emergency verbal authorization request should be made to the appropriate department director.

Upon approval, the Service Coordinator can make verbal arrangements with the vendor to provide the emergency services/supports prior to the receipt of a written authorization. Refer to approval process.

III. Procedure for Referral

In order to justify the provision of purchased services/supports prior to written authorization, the following information must be recorded in an Interdisciplinary (ID) Note in the consumer's record and accompany the routine request for purchase of services/supports which will be completed later.

The above information will suffice as temporary approval. However, the services/supports must be requested in the routine manner **within the**

next two (2) working days. All Purchase of Services/Supports standards apply to emergency services/supports and appropriate documentation must accompany the routine request, and must be outlined in the Person Centered IPP or IPP addendum and must be vendor specific, specify start dates, frequency and anticipated outcome.

During hours when the Regional Center office is closed, verbal authorization to the vendor for such emergency services/supports can be made by the Emergency Response Person with approval of the management back-up person. Within the first business day the office is open after the verbal authorization is given, the Service Coordinator will complete the emergency procedures as indicated.

1. Current date and time.
2. Name of approving person
3. Name of vendor.
4. Nature of services/supports
5. Date of services/supports implementation.
6. Rationale for emergency.
7. Relationship of emergency services/supports to consumer's eligible condition.

Only services/supports necessary to respond to the emergency situation may be authorized in this manner. Authorizations for the purchase must proceed through normal review processes in two (2) working days after the emergency situation. At that time requirements of the appropriate P.O.S. Standards shall be applied.

IV. Approval Process

The appropriate Program Manager, and Director of Children and Adult Services and/or Director of Consumer and Program Services or designee or after-hours back-up person will approve the emergency services/supports once it is deemed appropriate according to the P.O.S. Standards. The Service Coordinator shall contact the respective secretary to schedule an appointment with the Director of Children and Adult Services and/or Director of Consumer and Program Services to review the emergency P. O. S. request. Once authorized, the Service Coordinator shall meet with the appropriate Fiscal Assistant who will enter the emergency P.O.S. request and assign an authorization number. The Service Coordinator will telephone or send via fax the authorization to the Service Provider. The Service Coordinator will keep a copy of the emergency P.O.S. request in the case record.

2541 Purchase of Services (P.O.S.) Request Approval Process

Decisions regarding appropriate services for individual consumers are made during the IPP/IFSP process pursuant to Welfare and Institutions Code §4646 & §4646.5. Documentation of those services, in the form of a Purchase of Service Request, is reviewed by the Program Manager and subsequently by the Compliance Review Committee, for correction of any errors, prior to being forwarded to the Fiscal Department for processing.

PURCHASE OF SERVICES (P.O.S.) TRANSFERS

2542 Purchase of Services (P.O.S.) Transfers Pursuant to SB391 (c)

Whenever a consumer transfers from one regional center catchment area to another, the level and types of services and supports specified in the consumer's individual program plan shall be authorized and secured, if available, pending the development of a new individual program plan for the consumer. If these services and supports do not exist, the regional center shall convene a meeting to develop a new individual program plan within 30 days. Prior to approval of the new individual program plan, the regional center shall provide alternative services and supports that best meet the individual program plan objectives in the least restrictive setting in accordance with SCLARC P.O.S. Guidelines.

Early Start's Prevention's Transfers to other Regional Centers:

Prior to transfer, the Prevention Service Coordinator shall include in the case record, all parent contact information and available records including any evaluations and Prevention Program Plan (PPP). Funds will not be transferred between Regional Centers for the Prevention Program consumers.

APPEAL PROCEDURES FOR FAIR HEARING

I. Written Notice Written notice or a Notice of Action is mailed to an applicant for or consumer of Regional Center services and/or his or her authorized representative (as defined in Welfare and Institution Code---"WIC"---§4701.6) via certified mail, return receipt requested. The written notice or Notice of Action must include the following information:

A. The nature of the action being taken by the Regional Center and the reason(s) for that action.
B. The effective date of the action and any law, regulation or Regional Center Policy supporting the action;
C. The agency with whom a state appeal may be filed; and
D. A copy of the fair hearing rights information packet, which includes a Fair Hearing Request form and a list of available advocacy services.

II. Procedure Upon Receipt of Fair Hearing Request [Early Start "Appeals" is referred to as Due Process]. Any Regional Center staff who first receives a Fair Hearing Request ("hearing request") must immediately deliver said hearing request to the Fair Hearing & Government Affairs Manager ("hearings coordinator"). Any Regional Center staff to which a verbal request for a hearing is made shall provide the person making the request with a hearing request form and shall assist the person in completing the form if he or she requires or requests assistance. WIC § 4710.5 (c).

Upon receipt of the hearing request, the Fair Hearing & Government Affairs Manager as the Regional Center Director's designee shall, within five working days, transmit a copy of the hearing request via facsimile ("fax") to the Office of Administrative ("OAH") statewide DDS Calendar Clerk in the Sacramento office.

Upon receipt of the hearing request, the hearings coordinator shall also immediately provide, via overnight mail, the applicant or consumer (collectively "claimant") or his or her authorized representative with written notice of the rights pertaining to informal meetings, mediation and fair hearings (that is, a copy of the fair hearing rights information packet), and written notice regarding available advocacy services, **unless** such information was previously forwarded to the claimant or his or her authorized representative with the written notice or notice of action referenced in Section I above. WIC §§ 4701,4710.6. If claimant or his or her authorized representative requests an informal meeting, the written notice referenced in Section I. B. above shall also confirm the mutually agreed upon date, time and place of the informal meeting. The Fair Hearing & Government Affairs Manager shall also notify the appropriate Regional Center director and program manager of the date of receipt of the hearing request, the informal meeting date and the fair hearing date and request their cooperation and assistance in preparing for the fair hearing and/or informal meeting. Such

assistance may include but is not necessarily limited to assisting the hearing coordinator in obtaining, reviewing and interpreting the claimant's Regional Center case file, or notifying and securing the presence of other Regional Center staff, consultants, specialist and/or vendors at the fair hearing or informal meeting.

III. Mediation If the claimant makes a written request for mediation, the hearings coordinator shall, within five working days, simultaneously fax the Regional Center's written decision to accept or decline mediation to OAH's statewide DDS Calendar Clerk in the Sacramento office OAH.

IV. Informal Meeting The Fair Hearing & Government Affairs Manager, as the Regional Center Director's designee, shall serve as the informal hearing officer and shall prepare an agenda for the informal meeting.

A. Following the informal meeting, if one is held, the Fair Hearing & Government Affairs Manager shall, within five working days, prepare a decision letter that comports with the requirements of WIC § 4710.7 (c). A Fair Hearing Request Withdrawal form ("Withdrawal") must be enclosed with the decision letter. The decision letter must essentially conform to the following requirements:

1. Advise that if the claimant or his or her authorized representative is satisfied with the decision of the Regional Center, he or she must withdraw the request for a hearing by completing the enclosed Withdrawal form; and
2. Advise that if the claimant or his or her authorized representative is dissatisfied with the decision of the Regional Center, his or her request for a hearing will proceed directly to the fair hearing in the absence of mutually agreed upon mediation.

B. Upon receipt of the completed Withdrawal form the hearings coordinator shall fax a copy of the Withdrawal to OAH.

C. The Fair Hearing & Government Affairs Manager shall also notify the appropriate Regional Center director and program manager of the date of receipt of the Withdrawal form or that the matter will proceed directly to mediation and/or the sate-level fair hearing. The director and/or the program manager shall in turn notify appropriate case management staff, clinical department staff, specialists, consultants and vendors of the need to be available for the state-level fair hearing.

V. Early Start Prevention Appeals Process Claimants can appeal SCLARC's decisions regarding the determination of eligibility for the Prevention Program by submitting a written request to SCLARC stating the reason for their disagreement

with the eligibility decision and submit any additional pertinent information they feel supports their position.

VI. Appeal of OAH Decisions The Fair Hearing & Government Affairs Manager shall forward copies of SCLARC's OAH hearing request decisions reviewed by the superior court to the Department.

FUNDING STANDARDS
HOP Judicial Commitment

HOP
JUDICIAL COMMITMENT

Service Code: 610 - Attorney/Legal Services

I. Definition

SCLARC consumers who reside in the community and Developmental Centers are judicially committed and require periodic judicial review for commitment and/or placements. The HOP (in re HOP Decision) is one of the most frequently used judicial commitments that may be funded by the Regional Center. The criteria and procedure for obtaining this commitment are as follows:

II. Criteria

An individual must be gravely/disabled or dangerous to self and others and unable to provide for his or her own needs for food, shelter or clothing. Annual renewals required.

III. Procedure

The Service Coordinator (SC) shall contact the Fair Hearing & Government Affairs Manager to inform him/her that a HOP is needed. The Fair Hearing & Government Affairs Manager will provide a resource for an attorney to represent the regional center. The SC will complete a Purchase of Service (P.O.S.) for the vendor (attorney). The cost for an initial HOP in Los Angeles County shall not exceed $2,500. Any additional cost will require Management approval. Any additional cost will require Management approval. The routine process for approving P.O.S. Requests should be followed. In Los Angeles County HOP renewals require the completion of an annual report only to the court. There is no cost to the regional center for a HOP Renewal unless there is a problem which requires an attorney. If an attorney is required at renewal, the same process for obtaining the attorney should be followed.

Note: (Please refer to the procedure for State Developmental Center Admission dated 04/01/91 regarding details on what must be included in the court report and steps to follow after the report is prepared.)

FUNDING STANDARDS
Conservatorship

CONSERVATORSHIP

Service-Code: 610 - Attorney/Legal Services

I. **Definition:**

A Conservatorship is a legal proceeding in which an individual or agency (the Conservator) is appointed by a court to be responsible for a person who cannot provide for his or her own needs for food, clothing, shelter and health, or is unable to manage his or her own affairs or resist fraud or undue influence (the Conservatee).

II. **Criteria:**

General Rule:

THE REGIONAL CENTER WILL NOT PAY FOR CONSERVATROSHIPS OVER THEIR CONSUMERS.

Exceptions:

If a court order is issued ordering the Regional Center to pay for legal fees for the Regional Center consumer. Standard procedures will still be followed regarding issuing recommendations regarding the need for the Conservatorship.

III. **Procedure:**

QUESTIONS WHICH MUST BE ADDRESSED IN DETERMINEING WHETHER A CONSERVATORSHIP IS NECESSARY

a. Why is the court/proposed Conservator asking that the consumer be conserved?
b. What decisions affect the financial well being of the individual with the developmental disabilities? What decisions is she or she unable to make? Can these decisions be made effectively through means other than the creation of a Conservatorship? For example. If the individual's income is limited to Social Security Income (SSI), money management may be accomplished through a representative payee.

FUNDING STANDARDS
Conservatorship

c. Is the adult who is mentally retarded or developmentally disabled capable of providing properly for his or her own personal needs, i.e. physical health, food, clothing, or shelter?
d. Will a family doctor continue to accept parental consent for medical treatment for a family member who is mentally retarded or developmentally disabled, even though that family member is an adult?
e. Does the Regional Center serving the developmentally disabled person recommend Conservatorship?

Within five working days after the Interdisciplinary Meeting, the Service Coordinator will issue a letter to the court outlining the Regional Center's recommendations regarding the proposed Conservatorship.

If the proposed Conservator is in need of referral information as to how to begin the process of conserving the proposed Conservatee, the Regional Center will provide information regarding community resources as to agencies, pro bono facilities and legal entities which provide assistance with Conservatorships. It is up to the proposed Conservator to determine which venue is appropriate for their particular situation.

The Regional Center does not actively pursue the Conservatorship of Regional Center consumers or to become the Conservator of Regional Center consumers. The Regional Center will consider all requests for Conservatorships and make recommendations accordingly.

The Interdisciplinary Team should also consider the ability of the Regional Center Executive Director to consent to medical treatment as outlined in Welfare and Institutions Code Section 4655 when appropriate.

Funding Standards
Consumer/Family Member Conference

CONSUMER/FAMILY MEMBER CONFERENCE ATTENDANCE

Service Code: 102 - Community Integration Training Program/
Individual or Family Training

I. Definition and Criteria

A. A conference is defined as any outside workshop/ seminar meeting whose primary objective is to present specific subject matter that addresses all or part of the consumer's diagnosis and/or need(s). The conference can range in time from a few hours to a day or two (2). A conference that extends beyond two (2) days requires the approval of the Executive Director.

A conference participant is defined as an adult consumer, consumer's parent/family member, conservator/legal guardian, or circle of support member approved by the consumer or his or her representative.

B. All generic resources providing similar services should be explored and exhausted first prior to requesting regional center funding. The conference participant(s) shall contact the regional center at least 30 days prior to the conference date.

C. Approval for one (1) conference per participant will be granted within the fiscal year. Funding will be limited to the conference alone not to exceed $200 per person. The agency will set aside a fixed dollar amount for consumer/parent conferences each year. Approval will be based on a first come first served basis. Meals that are not included in the cost of the conference will be the responsibility of the participant. Transportation, lodging, and child care are the responsibility of the participant, however, family supports may be considered on a case by case basis. All exceptions will require prior approval from the Executive Director.

Funding Standards
Consumer/Family Member Conference

Funding Procedure

If services or supports are appropriate under the respective criteria, after exploring and exhausting all generic resources the Service Coordinator (SC) should complete a Purchase of Service (POS) Request and submit along with a copy of the completed conference application. The conference application should identify the cost of the conference, name, date, location and the number of days for attendance. Reservation for the conference is the primary responsibility of the SC and/or parent. To obtain authorization for the request, the SC should follow the same procedure for submitting POS Requests.

FUNDING STANDARDS
Burial Trust Disbursement Policy

Burial Trust Disbursement Policy

Overview

A one time irrevocable Burial Trust account can be established in the amount of $1500.00. This account is not considered a resource for Social Security purposes. SCLARC has established for its consumers an interest bearing account with a financial institution. Currently Lincoln Heritage Memorial Plan is the financial institution that SCLARC contracted on behalf of the consumers for the purpose of burial policies.

Procedure

1. Burial Trust establishing procedure:
    a. To establish a burial trust for a consumer, a complete Spend-down agreement form must be submitted by the service coordinator to the revenue unit. Upon receiving the burial request, the revenue staff will establish the trust account.

2. Burial disbursement procedure:
    a. When the service coordinator is informed of the consumer's death, a completed Revenue Request form must be forwarded to the fiscal (revenue) department by the assigned service coordinator. The completed revenue request should indicate the date of death, name and contact of family member/caregiver/ circle of support, and the name of the mortuary.
    b. Then the revenue staff will contact the mortuary to obtain an invoice from the mortuary for their records.
    c. Once the invoice is received from the mortuary, the fiscal department will call the insurance carrier to let them know that the consumer has expired and where and when the burial ceremony will take place.

FUNDING STANDARDS
Consumer Fund Balance
In Excess of $2,000.
Disbursement Policy

Consumer Fund Balance In Excess of $2,000 Disbursement Policy

Overview

The maximum resource limit set forth by Social Security for any individual consumer is $2,000.00. However, instances do exist whereby a consumer receives Social Security benefits in excess of the standard monthly payments. These additional benefits accumulate in the respective consumer's trust account and after a period of time will exceed the $2,000.00 resource limit imposed by Social Security. Therefore, in order to maintain a consumer's trust account balance below the $2,000.00 threshold, disbursements for the benefit of the consumer need to be generated. The Revenue Department is responsible for notifying the consumer's respective Service Coordinator that a disbursement of funds is necessary in the form of a Spend-Down Agreement Form.

The following policy is set forth in regards to Spend-down Requests by the Service Coordinators upon receipt of a Spend-Down Agreement Form.

Procedure

1. Service Coordinator will have to find out if the consumer has a burial/life insurance policy in place, by calling a family member, or asking the facility. If a burial/life insurance policy already exists, then the service coordinator needs to discuss with the consumer to find out his/her needs.
2. Service Coordinator must complete the Spend-Down Agreement Form and forward it to the fiscal department with all required signatures.
3. Fiscal staff will deliver to the Service Coordinator the spend-down check and the Spend-Down Agreement Form. The vendor must sign the Spend-Down Agreement Form in order to receive the check. Once the check is disbursed the service vendor must submit the original receipts to fiscal department within 15 working days from the date they received the check.

Note: no credit cards or debit card receipts will be accepted as proof of purchase. Only original receipts with a store name, address and contact number will be accepted.

Failure to adhere to the above policy will result in the withholding of funds from the vendor/provider payment.

SOUTH CENTRAL LOS ANGELES REGIONAL CENTER
CONSUMER SPEND-DOWN AGREEMENT

(One form per consumer)

PROVIDER/VENDOR NAME: _____ DATE: _____

CONSUMER NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____ UCI#: _____

ORIGINAL RECEIPTS MUST BE PROVIDED

This Spend Down Agreement for _____
(Consumer Name)

indicates dollars available to purchase items solely for this consumer. A check in the amount of _____ is attached and can be used only to cover the agreed upon listed items. ***No credit card or debit card receipts will be accepted as proof of purchase.*** Original receipts for expenditures must be submitted to SCLARC within 15 working days from the date the check is received. Your signature below indicates agreement with the terms as cited.

	ITEM(S)	ESTIMATED COST
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
	TOTAL ESTIMATED COST:	

Service Coordinator Date _____ Provider/Vendor Date _____ Other (Relative) Date _____

Unit Manager Date _____ Administrative Services Date _____ Director/Assistant Director Date _____

FAILURE TO COMPLY WITH ALL THE TERMS OF THIS AGREEMENT WILL RESULT IN A REDUCTION OF UP TO _____ FROM SUBSEQUENT INVOICES. _____

Enter Dollar Amount *Provider Initial/date*

Distribution: White copy = Administration Yellow Copy = Provider/Other Golden Rod = File (04/04)

DDS Approved 10/18/2010

GUIDELINES OF ESTIMATED COSTS

Most Frequently Purchased Items

All items purchased for a consumer are the sole property of the consumer and shall accompany the consumer to any future location.

Items You Can Buy	SCLARC's Maximum Amount For Items
Clothes	$500.00
Shoes	$200.00
T.V.	$300.00
DVD Player	$100.00
DVDs / Tapes	$ 75.00
VCR	$100.00
VCR Tapes	$ 75.00
T.V. with DVD Player	$400.00
T.V. with VCR Player	$400.00
Portable CD Player	$100.00
CDs or Cassettes	$ 75.00
Beauty Salon (Hair and Nails)	$100.00
Barber Shop	$ 20.00
Play Station/X Box/Nintendo	$200.00
PlayStation Games	$ 75.00
Stereo System (Radio, CD Player and/or Cassette Player)	$300.00
Social/Recreational Activity	$200.00
Hotel	$150.00/night
Per Diem	$ 35.00/day
Vacation (Detailed Budget)	
Other: (Detail)	$300.00
Other: (Detail)	
Other: (Detail)	

If a consumer has over $1,800.00 in trust at SCLARC and does not have a burial/life insurance policy, a policy will be purchased as a priority for the consumer by the Center .

(04/04)

FUNDING STANDARDS
Over $10,000 Policy

Over $10,000 Policy

I. Overview

Consumer with trust balance over $10,000.00 balance will require the establishment of a special needs trust account (Master Trust of California) which is administered by Inland Regional Center. In order to establish such an account, the court most likely will appoint a conservator to the consumer. SCLARC's Fair Hearing & Government Affairs Manager will coordinate with a SCLARC attorney to establish a conservator and any other legal related issues regarding this matter.

There will be an initial set-up fee assessed at the time funds are transferred to the special need accounts paid from the consumer's special needs trust balance after the account is established.

If a consumer needs money from his/her special needs trust account, Fiscal Department staff shall call the special needs trust department at Inland Regional Center.

II. Procedure

1. The revenue staff will inform the Service Coordinator to contact SCLARC's Fair Hearing & Government Affairs Manager. The Fair Hearing & Government Affairs Manager shall contact a SCLARC attorney regarding the consumer's need for a special needs trust account.

2. SCLARC attorney shall contact the service coordinator for any information required to complete the special needs trust account.

3. The Service Coordinator shall receive a package of **time limited forms** from the SCLARC attorney to be completed and signed by the Executive Director. It is necessary that the Service Coordinator make copies of the complete package before submitting for approval signatures.

4. SCLARC's Fair Hearing & Government Affairs Manager shall contact the Revenue Department informing them that the consumer's special needs trust account has been approved.

5. The revenue department shall transfer all benefits to the Inland Regional Center for establishing a special needs trust for the consumer. From this point on SCLARC has no control over this special needs trust account.

FUNDING STANDARDS
Genetic Services

GENETIC SERVICES

Prenatal Diagnosis (Amniocentesis)

Service Code: 800 - Genetic Counseling

I. Definition

A prenatal diagnostic procedure involves examination of cells for chromosomal abnormalities. Amniocentesis is usually performed within the 14th and 16th week of pregnancy, but can be done up to the 20th week (fifth month). Chorionic Villi Sampling (CVS) is performed between the 9th and the 11th week. These procedures are used for pregnant women who are considered to be at "high risk" for having an abnormal offspring. If a chromosome abnormality is detected, the parents may choose from several options one of which is to terminate the pregnancy following appropriate genetic counseling.

II. Indications for Prenatal Diagnostic Procedures

A. Maternal age - 35 years or over by time of delivery.

B. Previous child with a chromosomal abnormality.

C. Carrier of a chromosome translocation.

D. Mother is a carrier of an X-linked genetic disorder.

E. Parents are carriers of recessive genetic disorders which are prenatally diagnosable.

III. Criteria

A. Any woman residing in the South Central Los Angeles Regional Center catchment area and who is “at-risk” of having an abnormal offspring is eligible for services.

B. Referrals are made from genetic centers, obstetrical and health clinics, private physicians, prospective consumers or family members and counselors.

C. All generic funding resources such as private health insurance, Medi-Cal, CCS, etc., must be explored before prenatal procedures are funded by Regional Center.

WIC §4659(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009.

D. All prenatal consumers are counseled individually regarding risk factors, prenatal diagnostic procedures, and regional center services. Service Coordinators and other Regional Center Personnel will attempt to allay any anxiety.

1. Telephone referrals are taken daily. (See attached referral form in forms section).

2. The funding consent and authorization as well as the consent for release of information are reviewed with the consumer. If they consent to the agreements as stated, they are asked to sign the forms.

3. Consumers are referred only to and from State approved Genetic Centers.

IV. Funding

A. Funding is requested for all prenatal diagnostic procedures only after consumer has been refused payment by Medi-Cal, CCS, generic resources and private health insurance companies. WIC 4659(2)(c)

B. Chorionic Villus Sampling (CVS), is not to be approved routinely. CVS should not be funded by regional center when generic resources, Medi-Cal, CCS, private insurance, managed care health plans, etc., provide the funding for amniocentesis.

C. Repeat ultrasonography or sonogram may be purchased when the initial results are questionable or abnormal and further evaluation is indicated to diagnose a developmental disability.

D. New genetic diagnostic techniques should be evaluated by the existing genetic advisory groups, prenatal diagnostic centers and the ARCA Prevention Committee, after which a recommendation can be made by the genetic physician consultant regarding appropriate prenatal studies/therapy which will be funded by the regional center.

FUNDING STANDARDS
Medical - Genetics

MEDICAL - GENETICS

Service Code: 800 – Genetic Counseling

Clinical genetics is the study of the possible genetic factors influencing the occurrence of clinical disorders. These services and subsequent genetic counseling can be provided by a physician, geneticist, nurse, social worker and genetic counselor.

Medical genetic services are usually provided at a medical center's Genetics Division. The clinical findings, i.e., physical signs and symptoms, laboratory findings and X-ray findings are reviewed. A differential diagnosis is made and complications, if any, are noted. Finally, treatment is planned, and prognosis is determined. Genetic counseling always precedes and follows the genetic evaluation.

Policy

SCLARC can no longer purchase genetic counseling services due to the changes in the law. Government Code Section 95020 (3) states "With the exception of Durable Medical Equipment, regional centers are prohibited from purchasing non-required services but may refer a family to a non-required service that may be available to an eligible infant or to toddler or his or her family." Non-required services are those services that are not defined as early intervention services and do not relate to meeting the special developmental needs of an eligible infant or toddler related to the disability, but that may be helpful to the family. These non-required services may include: child care, diapers, dentistry, interpreters, translators, genetic counseling, music therapy, and respite services not related to developmental delay. The granting or denial of non-required services by a public or private agency is not subject to appeal under this law. "However, any person eligible for initial intake or assessment services, regional centers may cause to be provided preventive services to any potential parent requesting these services and who is determined to be at high risk of parenting a developmentally disabled infant, or, at the request of the parent or guardian, to any infant at high risk of becoming developmentally disabled. It is the intent of the Legislature that preventive services shall be given equal priority with all other basic regional center services". [Welf. & Inst. Code § 4644 (a)]

FUNDING STANDARDS
Infant Developmental Assessments

INFANT DEVELOPMENTAL ASSESSMENTS

Service Code: 773 - Occupational Therapy
772 - Physical Therapy
785 - Psychologist
775 - Physician
707 - Speech Therapy
116 - Early Start Specialized Therapeutic Services

I. Definition

Developmental assessment includes the use of informal and formal evaluation procedures to determine the status of infants and young children in the following areas:

1) cognitive development
2) motor/physical development, including vision and hearing
3) communication development
4) social/emotional development
5) self-help/adaptive development
6) health and safety developmental status

The status of information in 5 out of 6 domains include the chronological age, if necessary percentage of delay in each area and factors that impact functioning. In addition, the assessment includes evaluation of behavior, regulation and sensory modulation, play, parent-child interaction, as well as consideration for areas of strength and weakness, family resources, supports and other environmental factors. The assessment may be conducted by qualified personnel from several disciplines, i.e. occupational/physical therapist, psychologist, physician (e.g. developmental pediatrician), etc. At SCLARC, the developmental assessment, along with information from other assessments and records, enables the Interdisciplinary Team to:

1. determine eligibility/re-determine eligibility
2. make recommendations for appropriate supports and services
3. monitor the child's development and
4. provide parent education and empowerment

II. Criteria

Infants birth-2.9 years of age referred to the Early Start Unit may already have a current (done within the past six months) developmental assessment. If not, request a copy from family and/or other appropriate agencies and submit to the Occupational/Physical Therapist Consultant for review. Screening tools are also utilized such as; The Ages and Stages Questionnaire, the HELP Screening instruments and The Denver Developmental Screening Test II. If further comprehensive assessments are required then the Bayley Scales of Infant Development III (BSID) may be utilized. If the infant has a scheduled appointment at SCLARC, a developmental assessment may be performed at that time. Generic sites that provide developmental assessments are listed below:

1. Hospital OT/PT Departments and Clinics.

2. Child development clinics (e.g. UCLA, Long Beach Memorial, MLK, etc.)

3. Specialty clinics at hospitals (e.g. Spina Bifida).

4. Neonatal Intensive Care Unit (NICU) Follow-Up Programs (i.e. LAC-USC, Huntington Memorial, CHLA, etc). *Note:* A neonatal assessment, done while the infant is in the NICU such as the Brazelton--is usually not appropriate for eligibility purposes.

5. California Children's Services (CCS) Medical Therapy Units.

6. Other programs for abused and neglected children such as The Children's Institute.

SCLARC clinicians will perform developmental assessments to determine eligibility for the Early Start or Prevention program and for intervention planning. They may refer to vendors to perform developmental assessments under special circumstances using the following guidelines:

A. Schedule with a vendored occupational/physical therapist if:

   1. The infant is less than 30 months old and:

      a. The primary concerns have to do with posture, movement, feeding, sensory integration, etc.

      b. There is a known or a suspected neurological or neuromuscular condition such as Cerebral Palsy, head trauma, Spina Bifida, Muscular Dystrophy, etc.

c. The infant has multiple medically fragile conditions: (e.g. tracheostomy, gastrostomy, cardiac condition, failure to thrive, etc.).

d. The infant has a genetic disorder or multiple congenital anomalies, deformities, etc. (e.g. Down syndrome, cleft palate/lip, congenital amputee, etc.).

B. Schedule with a vendored psychologist if:

1. The child is over 30 months (2 1/2 years) old

C. Schedule with the SCLARC physician if:

1. A medical and a developmental assessment are needed.

2. There are complex medical issues, diagnostic issues (e.g. rule out Cerebral Palsy), or the consumer is medically fragile.

3. The child is transitioning from the Early Start Unit and there is a suspected diagnosis of Cerebral Palsy or Epilepsy.

D. Schedule with the speech pathologist if:

1. Communication and/or speech/language issues are of primary concern and a current assessment has not been done.

2. Consultation is needed for recommendations regarding communication and/or speech/language but there is sufficient data otherwise to determine eligibility.

3. Determine eligibility for Regional Center, for high risk consumers 30-36 months of age and/or for diagnosis. All re-assessments should be done by a psychologist. If the consumer has been in a program, a discharge evaluation should be done by the program and can provide additional information. If the consumer is receiving services from CCS the Medical Treatment Unit (MTU) summary may also be useful; however, these resources do not replace the psychological assessment because a diagnosis is needed to determine eligibility.

E. Regional Center shall fund developmental evaluations that are necessary to determine eligibility, treatment, plans and goals. Referrals should be made to a generic resource for ongoing treatment pending outcome of evaluation.

F. Early Start Specialized Therapeutic Services and assessments should only be used when there are no alternative resources available to meet the developmental needs identified in the Individualized Family Services Plan.

All generic resources for funding assessments should be explored through public agencies, (Medi-Cal, managed care plans, CCS and private insurance plans) prior to requesting POS funding for the assessment. Occupational, Physical, Speech and Language therapist who are authorized to provide this specialized assessment must directly provide the service as opposed to using an assistant or associate under their direct license or supervision.

FUNDING STANDARDS
Infant Development Programs

INFANT DEVELOPMENT PROGRAMS

Service Code: 805 - Infant Development Program

I. Definition

A. Infant Development Program (IDP) refers to a structured environment in which staff designed programs (or sets of selected activities) for developmentally delayed and at risk infants facilitate their development and/or prevent further delays in the gross motor, fine motor, adaptive/cognitive, language and personal-social domains.

B. The programs are most often carried out in a group setting, in which individual objectives and goals are set. However, some programs are carried out in a one-to-one setting (such as in-home programs). Most programs encourage active participation by parents and other family members. Various levels of assessment, monitoring and programming services are provided. Staff may have different levels and types of training.

A. Developmental programs attempt to meet the general developmental need of the children in the program in all areas of development. Such programs are to be distinguished from therapy programs in which services are provided by physical or occupational therapists.

II. Criteria

A. Infants 0-3 years of age with obvious developmental delays regardless of diagnosis (e.g., CP, Down syndrome, etc.) based upon recent assessment (less than six months).

B. SC's should consult with the programs prior to referral regarding their ability to accommodate consumers with certain medical conditions (e.g., gastrostomy, tracheotomy, respiratory problems, etc.). The family should also be advised to visit at least two (2) programs prior to the final referral being made. This will enable the family to make an informed decision by providing them the opportunity to consider such factors as geographical location, environment and teaching methods/techniques used by the program staff.

C. Infants who are medically eligible for California Children's Services (CCS) should be referred to the nearest Medical Treatment Unit (MTU) for occupational or physical therapy programs. IDP services may be used as a supplement to OT or PT programs, when appropriate, depending on the needs of the child.

D. Infants who are medically fragile or very young may be referred to in-home programs.

E. Infants who are not eligible for CCS, Medi-Cal or lack private insurance primarily that require OT or PT services may be referred to therapy programs vendored by the Regional Center. (Medi-Cal or Regional Center vendors).

F. Infants who require developmental stimulation with OT or PT consultation should be referred to programs where these specialists are available. Most Regional Center infant programs have consultants available.

G. Infants who may benefit from peer interaction, socialization and language stimulation may be referred to a center-based program. Younger infants also may be referred to a center-based program if appropriate (consult with SCLARC OT/PT and/or Nurse Consultant).

H. In-home programs will be reviewed periodically (usually every six months or more frequently, if indicated) and may be modified specific to the needs of the child. Keep in mind that infants receiving in-home services are generally younger and may be medically fragile (18 months or younger). Therefore, tolerance level for intervention must be considered.

I. Center-based infant programs shall be based on the individual needs of each child.

Any exceptions to the above standards require a consultation with the SCLARC OT and/or Nurse Manager or the Planning Team prior to authorization.

III. Procedure

A. Government Code 95020(d)(5)(B)(ii) Effective July 1, 2009, at the time of the development, review, or modification of the IFSP, the regional center shall consider the purchase of neighborhood preschool services and needed qualified personnel, in lieu of infant development programs. Service Coordinators (SC) should explore

the available pre- school services that will meet the consumer's needs.

B. Each referral for infant development programs must be evaluated by the SCLARC Occupational Therapy Consultant and/or Nurse Consultant prior to authorization. Authorizations will not exceed 36 months.

C. Except as outlined below, authorizations may not be granted beyond 36 months. Children who are three years of age and are found to be eligible (under the Lanterman Act) for ongoing SCLARC services, will be extended through the summer months or until a school start date has been provided via the school IEP, etc. This should not exceed a three (3) month period, except under special circumstances. Other exceptions are evaluated on an individual basis by the OT consultant or Nurse Consultant. Referral or transition activity to an appropriate preschool or early intervention public school program shall begin at age 2.6 years old.

D. The Infant Developmental Program (IDP) initial evaluations, Quarterly, Semi Annual report and closing summaries will be sent to the appropriate Service Coordinator for inclusion in the case record.

E. A written report regarding consumer's progress on the established goals and objectives should be assessed and/or reviewed every three to six months by the IDP. However, the IDP must always provide a written report of consumer's progress to the Service Coordinator. This report shall include consumer's current level of functioning in the following areas: fine/gross motor, cognitive, language, social and adaptive skills.

FUNDING STANDARDS
Early Intensive Behavior
Intervention Treatment
For Children with Autism

EARLY INTENSIVE BEHAVIOR INTERVENTION FOR CHILDREN WITH AUTISM

Service Codes: 612 – Behavior Analyst
620 – Behavior Management Consultant

I. Definition:

Autism is associated with pervasive and often severe disturbances in development, primarily in the areas of social skills, verbal and nonverbal communication. Research suggests that *young* children with this disorder can benefit from early and intensive intervention employing comprehensive treatment programs. These intensive and comprehensive treatment programs require collaboration and coordination among service providers and families. One such educational and therapeutic program for the consumer and their family is Discrete Trial Training (DTT). Other educational and therapeutic programs which might be considered for young children with Autism may include speech therapy, occupational therapy, infant development programs and the Developmental Individual Differences Relationship-based approach (DIR).

For children age 18 to 36 months, and pursuant to the California Government Code Early Intervention Services Act, sections 95000 et.seq., a combination of services will be recommended for a child by the interdisciplinary team developing the Individualized Family Service Plan (IFSP). Intensive intervention services agreed upon by SCLARC and the parents, guardian or legal representative, may include a single service or a combination of services provided for a total of six to thirty hours per week, depending on the needs of the child and family.

Children 3 years of age and older, who are eligible to receive regional center services pursuant to the Lanterman Developmental Disabilities Services Act, the Local Education Agency (LEA) and any other generic resource that is available is expected to be the primary provider of education and related services for children with Autism, including DTT.

Supplemental intensive services may be funded by SCLARC pursuant to an Individual Program Plan (IPP).

When there is an indication that a consumer may benefit from DTT, the Service Coordinator should consult with the family and/or caregiver and discuss with them early intensive behavioral intervention, criteria for purchase of this service/support, policies regarding school and regional center funding of the intervention and alternatives to this intervention. The letter addressed to care providers to inform them about DTT services and expectations for caregiver participation in the intervention should be sent to the family/caregiver. The letter should be dated and co-signed by the Behavior Specialist (via electronic signature) and the Service Coordinator. (See attached letter in Form Section)

Early intensive services may not be warranted if the child with Autism has severe behaviors, medical problems or a very limited cognitive ability, any of which may preclude the child from receiving intended benefit from programming. The intensive task demands associated with services may serve to exacerbate existing behavior problems. For such cases, it may be best to provide behavioral modification intervention to address these problems prior to beginning the educational or therapeutic programs described in Appendix A. Research has shown much more limited benefits from DTT for children with severe cognitive deficits.

Intensive Early Behavioral Intervention services may be available from generic sources. SCLARC may not provide the behavioral services until proof has been submitted that private insurance or the family's health plan do not cover the service. This includes, but is not limited to; private insurance, the local education agency, Medi-Cal, managed care plans and California Children's Services. If SCLARC does provide vendored service, the least costly available provider of comparable services shall be selected.

For ongoing intensive services, parents/guardians must demonstrate a willingness and ability to participate in programming as directed by the service provider or providers. Continuation may be recommended if the care providers have actively participated in and are committed to be fully involved in the intervention.

The interdisciplinary team shall consider all of the following when selecting a provider of services and supports: a provider's ability to deliver quality services or supports which can accomplish all or part of the consumer's IFSP or IPP; a provider's success in achieving the objectives set forth in the individual program plan: where appropriate, the existence of licensing, accreditation or professional certification; the cost of providing services or supports of comparable quality by different providers, if available; the parents/guardian choice of providers.

Prior to approval for funding, all ongoing early intensive services for children with Autism must be supported by an assessment prepared by a

qualified professional trained in the discipline. Reports submitted by parents/guardians will be reviewed as a part of the process.

Early intensive services may be authorized for no more than four months at a time. The vendor shall prepare a progress report at the end of the third month after commencement of the service, and quarterly thereafter. Services shall not continue unless the parent/guardian is satisfied and the parent/legal guardian and SCLARC agree that the planned services have been provided and reasonable progress toward the objectives has been made.

Parents and guardians are expected to take advantage of training provided by generic resources and free training provided by SCLARC prior to, or in conjunction with, the child receiving individualized services funded by SCLARC to address behavior issues.

II. Criteria:

1. The child has a diagnosis of Autism or suspected Autism.
2. The child is between 18 and 36 months of age.
3. The child is 36 to 83 months of age with Autism, is receiving intensive programming from their Local Education Agency (LEA) pursuant to an Individualized Education Program, the criteria listed in numbers 1 and 4-6 are met, and it is agreed upon through the regional center individual program planning process.
4. That supplemental funding for intensive services is warranted.
5. The child is in good health and without chronic medical issues or severe challenging behaviors (e.g. aggression, self-injurious) which would preclude full participation in the program(s)
6. The child has cognitive and adaptive abilities allowing them to benefit from the intervention.
7. The parent/responsible caregiver is willing and able to actively participate in the intervention sessions and to work in partnership with the interventionist(s), other service providers, and SCLARC to meet established goals and purpose of the service.
8. If the parent/caregiver of a child with Autism would benefit from training in behavior interventions and other strategies to be implemented in the home and has completed appropriate parent training course(s) provided by SCLARC or a generic resource, SCLARC may consider funding for in-home services to address behavior issues.

III. Procedure:

1. Prior to requesting an early intensive behavioral intervention treatment program, SC needs to ensure that all generic resources for funding services, including, but not limited to, public agencies and benefits such as the LEA, Medi-Cal, managed care plans, California Children Services and private insurance, must be pursued prior to SCLARC funding any service. (WIC Section 4659 (c)). Proof must be obtained to show that private insurance or the family's health plan does not cover the service and that the denial has been appealed or until it is determined by SCLARC that the appeal does not have merit. (Welf. & Inst. Code section 4659(d)(1). However, SCLARC may fund an intensive early intervention treatment program during the following periods:
    i. While coverage is being pursued, but before a denial is made.
    ii. Pending a final administrative decision on the administrative appeal if the family has provided to the regional center verification that an administrative appeal is being pursued.
    iii. Until the commencement of services by Medi-Cal, private insurance or a health care service plan. (Welf. & Inst. Code §4659(d)(1)(A)(B)(C).
2. If the parent/guardian, legal representative, or a qualified professional determines that DTT may meet the needs of the consumer, the Service Coordinator shall submit all documents pertaining to the consumer's existing services, including assessments, progress reports from SCLARC vendors, and any other relevant information from generic agencies, for an Interdisciplinary Team (IDT) review. The IDT should consist of the parent/guardian or legal representative, the Service Coordinator, a Program Manager and the appropriate clinical specialist(s) with an understanding of the service(s) being requested.
3. The letter addressed to care providers to inform them about DTT services and expectations for caregiver participation in the intervention should be sent to the family/caregiver.
4. The interdisciplinary team shall discuss the parent's concerns, goals and desired outcomes for the child, impact of the program(s) on the family, and the exploration of other service options, when appropriate. Once the interdisciplinary team agrees that any particular therapeutic or educational program is appropriate, the Service Coordinator will prepare the necessary POS request(s) and the objective(s) will be added to the IFSP/IPP. The maximum number of hours allowed for any DTT POS assessment shall not

exceed 16 hours; services under SMA rates remain in accordance with their allowances. The maximum number of intervention (treatment) hours for any service or combination thereof, shall not exceed 30-hours per week.

5. Any service(s) approved will be authorized for no more than four-months at a time. The vendor shall prepare a progress report at the end of the third month and quarterly thereafter. Services shall not be duplicated. No service should duplicate or interfere with the delivery of another service.

6. For children approaching age 36 months, and pursuant to the requirements found under the California Early Intervention Services Act and Title 17 of the California Code of Regulations, a transition meeting shall be held to discuss the transition of services and supports provided to the child and family under SCLARC's Early Start program to local education agency, under Part B of the Individuals with Disabilities Education Act. Among other things, there should be a discussion between the parent/guardian, the representative of the LEA, and the SCLARC Service Coordinator, about any and all appropriate intensive and comprehensive services for the child, some of which may need to be provided in the child's home.

7. For children over age 3 years and eligible to receive regional center services pursuant to the Lanterman Developmental Disabilities Services Act, SCLARC may agree to fund a portion of an intensive program for the consumer provided primarily by the LEA. The purpose of the SCLARC-funded portion is to help generalize learning which occurs in the educational setting to the home and community. The SCLARC-funded portion of the intervention may be up to 25% of the total.

   The school system and SCLARC will work together to transition the student into an appropriate educational program entirely in the school setting.

   In such cases, it is generally preferred that the vendor providing the programming funded by the LEA and SCLARC, be the same in order to ensure a consistent programming. If service providers are different, there must be an agreement made pursuant to which providers share information and collaborate in developing goals/interventions for the consumer. The parents must also agree to assist in assuring that reports created by school funded service providers, and other information, are provided to SCLARC and its vendor. The number of hours of programming to be funded by SCLARC will be determined by the interdisciplinary team on an individual consumer basis, depending upon the child's individual service needs. In such cases, the interdisciplinary team shall consider, among other things, the types and amount of services

being provided to the child from all agencies and individuals, and the total number of programming hours the child receives per week.

8. If SCLARC and the parent/guardian, agree upon a certain service or services, an IFSP, IPP, or addendum, should be prepared to include the agreed upon service(s). The IFSP, IPP, or addendum should include the specific goal related to the service. It should also include the statement that the parent/guardian agrees to fully participate in the programming and implement strategies as recommended by the service provider. New services shall not commence until the IFSP, IPP, or addendum is signed by the parent/guardian.

IV. Reauthorization

1. Once services have begun, the consumer's progress will be reviewed periodically by a clinical specialist knowledgeable about the service, or in cases where a combination of services is provided, the review should be conducted by the IDT. The Service Coordinator is responsible for collecting the progress reports from service providers and forwarding them to the appropriate clinical specialist, or where there is a combination of services, scheduling an IDT review.

2. Each service provider must prepare and provide to the Service Coordinator a quarterly report of the consumer's progress and the report shall address the following:

    - the consumer's past and present skills
    - current goals and objectives
    - methods and strategies used to achieve the stated goals and objectives
    - a summary of the consumer's progress toward the service goals, including data collection or other qualitative information detailing the specific ways in which the consumer is interacting with their environment and generalizing the skills
    - the frequency of contact and number of hours the consumer received the agreed upon service
    - information about the parent/guardian's responsibilities with regard to the service, such as implementation of strategies and compliance in meeting their responsibility

In addition to the progress reports, SCLARC may request any other supportive documentation form a service provider considered relevant to the consumer's progress, such as progress logs, attendance records and types of assignments given to parents/guardians to implement. SCLARC staff shall be permitted to observe the consumer during programming with parental consent. Documents and other information provided by the vendor or obtained as a result of staff's observations of the program, shall serve as a means for determining if the service should be continued, modified or terminated.

3. Service hours may be modified or adjusted at the end of any authorization period depending upon, among other factors, the consumer's ability to participate in the intervention(s), their progress in a particular area and the needs and preferences of the family.

4. Evidence or grounds of terminating a service may include one or more of the following:

    A. the consumer has met the goals of the service and has demonstrated excellent progress such that the intervention is no longer necessary;

    B. the consumer shows evidence of generalizing skills into natural settings;

    C. the consumer attains the age of 7;

    D. maladaptive behaviors have developed that interfere with the achievement of goals;

    E. a SCLARC clinical specialist or the interdisciplinary team conclude that there is insufficient progress to warrant continued funding following the authorization period;

    F. parents/guardians are unable or unwilling to fully participate or otherwise comply with their responsibilities related to the service; the parent/guardian decides to discontinue the intervention at anytime

5. Should a decision be made by SCLARC to terminate a service, the parent/guardian will be offered an opportunity to meet with the appropriate clinical specialist to review the concerns. If after meeting with the appropriate clinical specialist, a disagreement remains regarding the provision of services, the parent/guardian may also request a review by the IDT.

6. As with all services provided pursuant to an IFSP, IPP, or addendum, any decision by the regional center without the mutual consent of the consumer or their legal representative must adhere to Welf. & Inst. Code section 4710 et seq. for consumers three years of age or older or to California Early Intervention Services Act, Government Code, section 95000 et seq., and Cal. Code Reg., Tit 17, sections 52000-52175, for children under the age of three.

FUNDING STANDARDS
Developmental Individual Differences Relationship Model

DEVELOPMENTAL INDIVIDUAL-DIFFERENCES RELATIONSHIP (DIR) MODEL

Service Codes: 605 -Adaptive Skills Trainer
055 -Community Integration Program

I. Definition

DIR, commonly referred to as Floortime, is a developmental approach that can be used with a variety of individuals who exhibit a continuum of challenges with relating and communicating. While it can be used with a variety of individuals showing these developmental challenges, the research and literature that is more widely known about its effectiveness has been on children with Autistic Spectrum Disorders (ASD), and it has been cited as having promising outcomes for children with ASD by the National Research Council (Educating Children with Autism, 2001).

DIR recognizes that young children learn best when engaged in spontaneous interactions that are enjoyable and build around their natural interests, and when they have attuned adults that respond appropriately to their developmental needs. A core and highly valued concept in the model is affect (emotions, feelings) and how it plays a central role to all learning. Affect will motivate the child to initiate actions, respond to others, interpret and generate ideas, and symbolize experiences. The child will bring different processing skills across modalities in order to learn, and the child must be challenged to keep reaching toward higher levels of interactions, problem solving, symbolic thinking and abstraction.

DIR works with all essential functional developmental capacities (regulation and attention, engagement, two-way purposeful interaction, problem-solving interactions, the creative use of ideas, and logical thinking), individual processing differences (auditory-language, visual-spatial, motor planning, and sensory modulation), and child-caregiver relationships and family functioning. Learning is child-led rather than adult-controlled, not to say that adults provide no direction in the process. The adult takes on a facilitative role using the child's natural interests as a way to build a continuous flow of interaction and expand learning. As a result of the emotional connections made, interactions between the child and

caregiver become more meaningful and pleasurable, so that learning can develop.

"The determination of which services and supports are necessary for each consumer shall be made through the Individual Program Plan (IPP) process or the Individualized Family Service Plan (IFSP) process for Early Start program eligible children. The determination shall be made on the basis of the needs and preferences of the consumer, or when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by the IPP or IFSP team, the effectiveness of each option in meeting the goals stated in the IPP or IFSP, and the cost effectiveness of each option. The IPP planning team shall consider the cost of providing services or supports of comparable quality by different providers, if available, and the least costly available provider of comparable service, including the cost of transportation, who is able to accomplish all or part of the consumer's IPP, consistent with the particular needs of the consumer and family as identified in the IPP, shall be selected. In determining the least costly provider, the availability of federal financial participation shall be considered. The consumer shall not be required to use the least costly provider if it will result in the consumer moving from an existing provider of services or supports to more restrictive or less integrated services or supports."
(Welf. & Inst Code §4512, subd. (b) and § 4648 subd (a)(6)(D), 34 CFR 303.344 and 303.527)

II. Criteria

1. The consumer is 18–36 months and has been seen and recommended by one or more of SCLARC's clinical specialists knowledgeable about ASD in young children and understands the principles and intentions of the DIR model to determine if it would be of benefit.

2. The consumer is 3–7 years of age, has a diagnosis of Autism, and receives special education programming through the local educational authority under the eligibility of Autism/autistic disorder through the IEP process, but demonstrates limited progression in the goals and skills that are ordinarily addressed through the special education curriculum (e.g., preverbal development, social precursors for language, engagement).

3. The child is in good health and without chronic medical issues or severe challenging behaviors (e.g., aggression, self-injurious) which would preclude full participation in the service.

4. The parent/caregiver is willing and able to actively participate in the intervention sessions and to work in partnership with the

interventionist(s), other service providers, and SCLARC, to optimally meet the agreed-upon goals and purpose of the service.

III. Procedures

1. For consumers 18–36 months that have had an assessment for intervention planning by one or more of SCLARC's clinical specialists who have recommended the service, the SC forwards the chart, IFSP, and POS to the appropriate clinician and funding committee for approval.

2. For consumers 3–7 years of age, the SC updates the chart with current educational records (most recent triennial psycho-educational assessment report, current IEP describing present level of functioning in all areas, goals, and services in place), SCLARC psychological and medical records, and reports from other vendors, to be forwarded to the appropriate clinical specialist for review. The SC also conducts an inquiry with the parent/caregiver about the expected goal(s) and outcome(s) anticipated from the service and forwards all information to the clinical specialist. If it appears that the consumer would benefit from the services of a DIR model after reviewing the information submitted, the consumer and parent/caregiver will have to meet with the appropriate clinical specialist prior to any authorizations. SC will then submit the chart, IPP/IPP addendum, and POS to the clinical specialist and funding committee for approval.

3. The initial authorization will usually include a DIR assessment for no more than 7-hours, including the report from the vendor. The SC forwards a copy of that report to the clinical specialist for review.

4. Authorizations for intervention will not exceed 6-months at any given time which should include a report of progress 30-days before the expiration of service. Early Start consumers may have a shorter authorization period depending on their age and time of exiting that program.

IV. Alternative Funding

1. WIC §4659(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but

chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009.

2. WIC § 4659(d) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not purchase medical or dental services for a consumer three years of age or older unless the regional center is provided with documentation of a Medi-Cal, private insurance, or a health care service plan denial and the regional center determines that an appeal by the consumer or family of the denial does not have merit.

FUNDING STANDARDS
Disposable Diapers

DISPOSABLE DIAPERS

Service Code: 627 - Diaper Service

I. **Definition**

South Central Los Angeles Regional Center may purchase diapers for children three years of age or older, or when the family can demonstrate a financial need and when doing so will enable the child to remain in the family home. SCLARC will also consider the typical responsibility of the parent when providing diapers to the child. WIC Code §4646.4 states that Regional Centers should take into consideration the family's responsibility for providing similar services and supports for a minor child without disabilities in identifying the consumer's services and supports.

II. Criteria

South Central Los Angeles Regional Center (SCLARC) may purchase diapers for consumers residing in the family home when there is no funding available for this service through a generic resource such as Medi-Cal, Social Security Income, Medicare CHAMPUS, Managed Care plans, California Children Services or private medical insurance. WIC §4659(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009. In order for SCLARC to purchase diapers for the consumer, the following conditions are considered:

1. The child is younger than 3 years of age, is a developmentally disabled individual and the family can demonstrate financial need and when doing so, will enable the child to remain in the family home. SCLARC may request documentation of parent's gross income by providing a copy of a tax return or a recent pay stub. The gross income must be at or below 200% of the federal poverty guidelines.

2. The consumer is 3 years of age or older, participating in a toilet training program both at home and at school and/or is enrolled in a toilet training program.

   SCLARC may require parents of children over three years of age to receive instruction in toilet training and to implement toilet training strategies as a condition to the provision of diaper purchase. SCLARC may include this condition only if the child demonstrates a readiness to respond to toilet training. SCLARC may require that such readiness be determined through a behavioral assessment. A toilet training program must be detailed in the consumer's Individual Program Plan if diapers are purchased under this scenario.

   Prior to re-authorization of this service, SCLARC may interview the parents, the vendor and others to determine progress and/or problems associated with the toilet training program.

   The Purchase of Service request must indicate details of the toilet training program, including who is providing the training, how often and the progress being made.

3. The consumer is 3 years of age or older, totally incontinent and unresponsive to toilet training due to medical or cognitive reasons. A physician's prescription or physician's statement indicating that the consumer has medical/physical disabilities that are directly related to the qualifying diagnosis for regional center services. Prior to authorizing the diaper purchase, SCLARC may assess the child's ability to respond to toilet training through a behavioral, medical or other assessment.

III. Alternative Funding Resources

Medi-Cal will fund for diapers for total or permanent incontinence at age five. Medi-Cal requires a physician prescription justifying incontinent supplies. Private health plans may also pay for diapers. CHAMPUS generic and family resources should also be considered.

IV. Request For Obtaining Authorization of Services

1. Service Coordinator will ensure that the consumer/parent has accessed generic resources (Medi-Cal, private insurance, Medicare, Civilian Health and Medical Program, etc). If the request is denied, consumer/parent will request the documentation of denial by generic resource. Service Coordinator will request financial information from parents (if the justification of the request is due to financial hardship) and review the diaper policy with the family.

2. Service Coordinator will request a physician's prescription or physician's statement indicating that consumer has medical/physical disabilities that are directly related to the qualifying diagnosis for regional center services. The prescription must also include the consumer's current weight and regional center diagnosis. Service Coordinator will forward information to Nurse Consultant for review.

3. Service Coordinator will complete authorization and submit to Nurse Consultant for signature (authorization will terminate for Medi-Cal eligible consumers at their fifth birthday) along with documentation of the denial and evidence of the appeal process from generic resources, managed care, private insurance, Medi-Cal, etc.

FUNDING STANDARDS
Medical/Dental/Laboratory Services

MEDICAL/DENTAL/LABORATORY SERVICES

Service Code: 775 - Physician/Surgeon
715 - Dentist
735 - Laboratory/Radiology
009 - Medicare Part D

I. Definition

Included in this category are a variety of medical, dental, laboratory and related diagnostic services necessary to maintain an optimal standard of health and enhance a consumer's development.

II. Criteria

SCLARC shall not fund the general health care needs of its consumers unless special circumstances exist. Parents are generally expected to provide for the medical and health care of their children. SCLARC will assist consumers and families in accessing services through existing health care resources. These resources may include but are not limited to: private health insurance, Medi-Cal, Medicare, CCS, CHDP/EPSDT, county health care services and fee for service providers. SCLARC shall not fund any medical or related services before existing generic resources for the service are explored. Consumers who are not covered by other generic resources should be referred to county health care facilities for their general medical needs.

WIC §4659 (c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009.

WIC §4659 (d) (1) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not purchase medical or dental services for a consumer three years of age or older unless the regional center is provided with documentation of Medi-Cal, private insurance, or a health care service plan denial and the

regional center determines that an appeal by the consumer or family of the denial does not have merit. If, on July 1, 2009, a regional center is purchasing the service as part of a consumer's IPP, this provision shall take effect on August 1, 2009. Regional centers may pay for medical or dental services during the following periods:

(A) While coverage is being pursued, but before a denial is made.

(B) Pending a final administrative decision on the administrative appeal, if the family has provided to the regional center verification that an administrative appeal is being pursued.

(C) Until the commencement of services by Medi-Cal, private insurance, or a health care service plan Welf. & Inst. Code section 4659(d)(1)(A)(B)(C). Funding will be considered under the following conditions:

1) A consumer demonstrates an exceptional need that is directly related to the consumer's developmental disability (as defined by regional center eligibility criteria).

2) SCLARC will consider funding services that will be formally **authorized prior** to provision of the service. SCLARC will not fund services without such a prior authorization.

3) SCLARC will fund services at applicable Medi-Cal Statewide Maximum Allowance (SMA) rates. In general health care services not funded by Medi-Cal will not be funded by SCLARC.

4) SCLARC shall not purchase experimental treatments, therapeutic services or devices that have not been clinically determined or scientifically proven to be effective or safe for which risks and complications are unknown.

On an exception basis, SCLARC may fund certain non-hospital, non-emergency health care services for consumers placed in Intermediate Care Facilities whose service needs are not covered by generic resources and who are not eligible for Medi-Cal. Although certain routine health care services may be considered for funding in these situations the other considerations described previously would apply.

Medical services which are deemed by the SCLARC physician to be important for determination of the consumer's eligibility or which are important for case management may be considered for SCLARC funding when no other resources are available.

Exceptional circumstances creating unusual or extreme needs for health care services will be evaluated for SCLARC funding on an individual basis. The SCLARC physician should be consulted prior to any decisions on provision of funding for health care services.

It is recommended that most consumers have periodic medical evaluations (usually annually). However, this routine medical care as well as any acute or chronic medical care is expected to be provided by the health care system (e.g., Medi-Cal, Los Angeles County hospitals and public health centers, private insurance, CHDP, etc. and other generic sources). Therefore, these services would not be funded by the regional center. A similar expectation exists with regards to dental services. The regional center may consider funding services on an individual basis as outlined earlier.

III. Procedure

A. The consumer's record should be available to the physician for review, in consultation with the SC before medical, dental, pharmacological or developmental services are authorized. The direct relationship of the service to the consumer's disability should be clearly documented.

B. Questions regarding medical/dental specialty, ethics or appropriate referral sources should be directed to the SCLARC physician.

C. Consumers who do not have Medi-Cal or Insurance may be scheduled for medical re-evaluation with the SCLARC physician in the following situations:

1. Pending emergency placement.

2. Entrance into a primary day program.

3. Participation in special events, e.g., Special Olympics, day camp and other recreational activities.

4. There is no baseline medical evaluation in the case record and to assist with determining eligibility.

NOTE: It is essential in these cases to have the complete case record, a reliable historian and a brief referral note from the SC accompanying the consumer to the evaluation.

D. Only in extreme and unusual cases will the SCLARC physician prescribe medication for consumer use. All consumers should be encouraged to seek medication management and appropriate laboratory follow-up through their private physicians or clinics.

Consideration will be given to funding medications which have a specific relationship to the consumer's disability as defined by Regional Center eligibility criteria, i.e., seizure medications.

Medical follow-up and supervision of medications must be documented before related services are funded by SCLARC. Adequate documentation includes written medical reports, and laboratory data which should be submitted by the attending physician. Vendored or private physicians whose care is financed by the Regional Center may define the frequency of follow-up visits, drug renewal periods and monitoring studies their consumer will require. These management suggestions will be accepted provided they are well documented and fall within acceptable, general physician practice and medical standard of care.

Consumers who are funded under Medi-Cal, or other generic resources should receive appropriate medical care, despite funding source. SC's may contact the SCLARC physician when in doubt as to levels of care or appropriateness of management.

SCLARC will provide POS funding for medication co-payments of up to $5.00 per medication for consumers who receive their medication benefits under Medicare Part D and reside in a residential facility. Under special circumstances, POS funding for medication co-payments for consumers receiving Medicare Part D benefits that reside independently or with family members will be considered.

All POS requests must be reviewed by the SCLARC Pharmacy Consultant. The POS request must include a current pharmacy print-out of the consumers' medications and indicate the consumers' Prescription Drug Plan (PDP) carrier. SCLARC shall not fund any experimental medications that have not yet been approved by the Food and Drug Administration or over the counter (OTC) drugs such as cough syrup, vitamins or aspirin. Co-payment POS authorizations may need frequent modifications throughout the fiscal year due to changes in the consumers' medication regime.

When submitting the co-pay POS requests, SC's are advised to **ONLY** use Service Code 009 for those consumers who are dual eligible, i.e., receiving Medicare and Medi-Cal benefits.

E. Diagnostic laboratory services recommended by the SCLARC physician which are essential for determination of consumer's eligibility and/or medical management may be considered for SCLARC funding when no other resources are available.

f. Laboratory services must be performed at appropriate/ recommended laboratories or clinics.

g. A copy of all medical and laboratory reports should be sent to the SCLARC physician.

h. In situations involving abnormal results, the SCLARC physician will contact the SC to advise on appropriate follow-up.

i. All pre-residential placement lab work will be submitted to the SCLARC physician prior to placement and should include:

a. TB evaluations
b. Syphilis
c. Hepatitis B
d. Microbiology: stool for ova and parasites; stool culture for Salmonella, Shigella, E. Coli, Campylobacteria and E. histolytica

F. POS requests for dental services must be reviewed by the SCLARC dentist or physician consultant prior to funding. The SCLARC dentist or physician consultant will assist in identifying appropriate dental specialties such as pedodontics to handle the emotional and special needs of the ~~our~~ consumers.

The SCLARC dentist or physician consultant must review all cases involving the use of anesthesia on unconserved adults or consumers conserved by the Department of Developmental Services.

1. A copy of the consumer's complete record, including medical history and a recent dental evaluation, should be forwarded for review.

G. Medical/ dental and drug authorizations are currently funded for an initial three month period only. Renewal requests must be submitted in advance of the third month deadline, and should be accompanied by documentation of appropriate on-going medical follow-up. Laboratory data must be submitted with re-authorization requests. SC's are advised to keep consumer records of prior and current medical reports and laboratory studies.

If consumers are diagnosed with chronic epilepsy and are stable on medications, renewals can be requested routinely at six-month

intervals. Bi-annual (6 months) or at least yearly serum levels must accompany these requests.

All funding for psychotropic medications must first be cleared by the SCLARC physician and accompanied by verification of need such as documentation of psychiatric care and a relevant diagnosis. No psychotropic drugs will be funded for consumers unless there is a mental disorder or other appropriate indication is properly documented.

IV. Consultation and Medical Clearance

SC's are encouraged to consult with the SCLARC physician, psychiatrist, dentist, pharmacist consultants and/or nursing staff on all medical, dental, psychiatric and pharmacological issues. However, they should consult first with their Program Manager prior to making a referral.

A primary goal for all consumers should be to assure that they are appropriately connected to the health care system and that they have an identified source of primary medical, dental and/or psychiatric care.

It is recommended that most consumers have periodic medical evaluations (usually annually). However, this routine medical care as well as any acute or chronic medical care is expected to be provided by the health care system (e.g., Medi-Cal, Los Angeles County hospitals and public health centers, private insurance, CHDP, etc. and other generic sources). Therefore, in general these services would not be funded by the regional center. A similar expectation exists regarding dental services. The regional center may consider funding services on an individual basis as outlined earlier.

FUNDING STANDARDS
Nursing Assessment

NURSING ASSESSMENT

Service Code: 744 – Registered Nurse
116 – Early Start Specialized Therapeutic Services

I. Definition

An assessment of the physical, psychological and social needs of the consumer based on data received from consumer's past history, chief complaints, treatment modalities, a review of body systems (subjective) and (objective) initiating recommendations for nursing care based on the current status of the consumer. This assessment may include, but is not limited to a review of the following subsystems: general appearance, aggressive behaviors, restorative needs, dependency needs, sexual needs, appropriateness of placement and appropriateness of facility.

II. Criteria

i. Multiple medical problems and/or complex medication regime

ii. Recent hospitalizations

iii. Unusual weight loss/gain

iv. Involved in special incidents resulting in injury

v. Frequent recurring infections

vi. Consumers with the following needs:

- Ventilation dependence
- Apnea monitoring
- Frequent suctioning
- Gastrostomy / Naso–Gastric (NG) tube
- Intermittent respiratory treatment
- Intermittent catheterization
- Colostomy/ileostomy

vii. Consumers who requires skilled nursing respite services

viii. Consumers who are confined to bed

ix. Consumers who are excluded from school or day program for medical reasons

x. In conjunction with requests for respite hours, or increased respite hours

III. Procedure

The Service Coordinator will consult with the nursing staff (face-to-face or telephone contact) regarding consumer's medical/ nursing needs. The SC will submit consumer's record and ensure that the current medical information is in the case records. Nursing staff will review case records prior to scheduling a home or a facility visit. The Service Coordinator will complete an addendum to the IFSP/IPP for services, requesting a nursing assessment or a follow up nursing consultation to be completed by a nurse vendor. All authorizations for nursing assessments must be signed by the Nurse Manager or their designee. Service Coordinator may be requested to accompany nursing staff at the time of the home or facility visit.

The Early Start Specialized Therapeutic Services nursing assessment code shall be utilized when there are no alternative SCLARC nursing staff or vendors available and it may only be utilized for children 0 to 3 years of age.

FUNDING STANDARDS
Nutrition Services

NUTRITION SERVICES

Service Code: 720 - Dietary Services

I. Definition

Nutrition - The sum of the processes involved in taking in nutriments and assimilating and utilizing them.

Disabling conditions can affect a person's ability to consume food, which in turn, can create an at-risk situation for malnutrition.

Malnutrition for an individual with a developmental disability can compound alterations in growth, structural and functional development of the central nervous and other systems, behavior and resistance to stress and disease.

Nutrition is crucial in both the prevention and treatment of persons with disabilities.

A. Assessment – A physician's prescription is required. Refer to criteria for referral for indications for a nutrition assessment. Some insurance companies and generic resources, such as Medi-Cal, will pay for an assessment (e.g., diabetic patients).

- Consumers receiving care at hospitals/clinics should be referred to the staff registered dietitian (RD.).

- Request CCS nutrition services ~~funding~~ for mutual consumers.

B. Education and Training - Service Providers
The Expanded Food and Nutrition Education Program (EFNEP) is a free resource. This program provides group nutrition instructions to low income families.

C. Nutritional Replacements/Supplements for metabolic disorders and medically diagnosed conditions which could result in a serious disability or death.

- Items required in the management of metabolic disorders have been funded by CCS, Genetically Handicapped Persons Program, Medi-Cal or other generic sources and private insurance companies

- If medically justified, a variety of supplements are a benefit of Medi-Cal, or other health care plans. Examples of liquid Nutrition supplements are: Nutramigen, Pregestimil, Ensure, Sustacal, PediaSure, etc. A written denial of service and documentation of the appeals process is required prior to requesting Regional Center consideration for funding.

II. Criteria

A. Delayed growth and development (infants/children - 3rd or 5th percentile).

B. Overweight -Child's weight for length measurement is greater than the 95th percentile on National Center for Health Statistics (NCHS) growth charts, or BMI (less than 2 years of age) is above the 97th percentile or in the obese range as determined by appropriate standards. If the consumer is over 20 years of age, 20% above the desirable weight range or has a BMI of 30 and above and causing significant health challenges a referral may be appropriate.

C. Underweight –Child's weight for length of measurement is below the 5th percentile on NCHS growth charts or BMI (less than 2 years of age) is below the 3rd percentile. If the consumer is over 20 years of age, 10% below desirable weight range or has a BMI less than 18 and causing significant health challenges a referral may be appropriate.

D. Sudden and recent substantial weight loss in the absence of medical monitoring.

E. Anemia in the absence of intervention.

F. Special diet which may include: Phenylketnouria (PKU), Maple Syrup Urine Disease (MSUD) and other prescribed therapeutic diets, etc.

G. Questionable nutrient intake due to allergies, diet lacking in protective foods, excessive intake of one food, (e.g., milk) at the expense of other foods.

H. High risk family (financial limitations, lack of education, etc.).

I. Chronic diarrhea, constipation or vomiting.

J. Feeding problems (nutritionally at risk because eating problems prohibit adequate food intake).

K. Gastrostomy tube or supplemental feedings for extended periods of time without monitoring (ideally, vendor R.D. and O.T. with physician's authorization for transitioning to oral feedings).

L. Decubitus ulcers.

M. Low caloric diets below 1000 calories per day without supplements.

N. Dental problems related to poor diet and/or bottle feeding.

O. Pica (the ingestion of non-food items).

P. Mega doses of nutrient supplements in the absence of monitoring supervision).

Q. Consistency of food inappropriate for developmental level (e.g., diet of puree foods).

R. Supplemental formula is necessary to maintain weight.

III. Procedure

A. The Regional Center's staff will submit requests using the Nutritionist Referral Form

B. The Clinician will identify the appropriate vendor based on required intervention and the service provider's area of expertise

C. The Clinician will determine the timeframe

D. The vendor will submit report to regional center staff for review

WIC Section 4648(a)(15) states that notwithstanding any other provision of law or regulation to the contrary, effective July 1, 2009, regional centers shall not purchase experimental treatments, therapeutic services, or devices that have not been clinically determined or scientifically proven to be effective or safe or for which risks and complications are unknown. Experimental treatments or therapeutic services include experimental medical or nutritional therapy when the use of the product for that purpose is not a general physician practice. For regional center consumers receiving these services as part of their Individual Program Plan (IPP) or

individualized family service plan (IFSP) on July 1, 2009, this prohibition shall apply on August 1, 2009.

FUNDING STANDARDS
Feeding Programs

FEEDING PROGRAMS

Service Code: 707 - Speech Pathologist
773 - Occupational Therapy

I. Definition

Feeding Problem - "The inability or refusal to eat certain foods because of oral sensory and/or oral motor issues

Studies have shown that feeding problems such as those seen in premature infants with G-Tubes, with genetic disorders (Down syndrome, Treacher Collins syndrome), neuromuscular disorders (Cerebral Palsy), infants with developmental delays and Autism are extremely susceptible to nutritional deficits. This population demonstrates challenges with low oral muscle tone, structural abnormalities, mechanical feeding challenges, oral sensory issues, motor planning difficulties and behavioral issues around the feeding process and those involved in feeding.

University Center for Excellence in Developmental Disabilities (UCEDD) study showed:

1. A correlation between low iron intake, adaptive behavior or the child's effectiveness in maintaining their independence and mechanical feeding problems.

2. A prevalence of feeding difficulties among children of lower intellectual functioning.

3. Children who are severely retarded in adaptive behavior and intellectual functioning also tended to be growth retarded.

A. Many individuals with developmental disabilities have feeding problems. Frequently, feeding problems are seen in infancy and can persist for many years. Thus early intervention is essential.

B. The assessment and management of persons with feeding problems require an IDT, which may include an Occupational Therapist, Physical Therapist, Nutritionist, Physician, parent or primary caregiver and teacher, a Psychologist, Speech Therapist, Dentist, Social Worker or Nurse depending upon the nature of the feeding problem and the needs of the consumer and family. The parents or primary caregiver and teacher are the most important

members of the team since they have the most contact with the consumer and carry out the feeding programs.

C. Services for consumers with feeding problems include evaluation and diagnosis, recommendation, treatment (direct and/or indirect such as parent education, development of a home program on feeding and behavioral techniques, etc.), monitoring progress and making adjustments in the program as indicated. Consistency in follow-through in the home and classroom is essential and the programs must be coordinated.

II. Criteria

A. Consumers of any age or diagnosis who present with feeding problems may be referred (see Signs/Behaviors That May Indicate Oral Sensory Oral-Motor/Feeding Problems in the "Forms Section"). All referrals must be reviewed by the OT and/or Nutrition Consultant.

B. Consumers with the following conditions that present with feeding issues may qualify for services:

1. Cleft palate, cleft lip or other orofacial deformities.
2. Children requiring tube feedings (e.g. nasogastric gastrostomy).
3. Down syndrome children.
4. Children with syndromes such as Cornelia de Lange, Prader Willi (early in life), etc.
5. Consumers with facial nerve palsies.

C. Parent and/or service providers or consumers in residential placement are expected to participate in the referral and follow-up process.

III. Procedure

A. If a consumer is suspected of having a feeding problem, refer to the Occupational Therapist or Nutrition Consultant. Attach pertinent information including the most recent medical evaluations, feeding

evaluations, swallow study, psychosocial, speech and language evaluation, etc. Include the nature of the feeding problem, height, weight, etc.

B. The consumer may be evaluated and followed by:

1. Any member of the Interdisciplinary Health Team (IHT) including a Nutritionist, Occupational Therapist, Nurse, Speech and Language Consultant or a primary care physician.

2. CCS, OT or PT, if consumer is medically eligible (refer to the nearest MTU - use CCS form.)

3. University Center for Excellence in Developmental Disabilities (UCEDD) (all referrals to UCEDD must be screened by the OT or Nutrition consultant). If services from UCEDD are indicated, the consultant will initiate and coordinate the referral.

4. Medi-Cal and private health insurance.

5. Follow-up may be coordinated by the Service Coordinator, OT, or Nutrition consultant.

C. Referrals for Medi-Cal and Regional Center vendored therapists require a prescription from the primary physician. Additionally, referrals for feeding evaluations and treatment necessitate medical clearance for consumers who are medically fragile.

The consumer may also need additional specialized evaluations such as dental, craniofacial, lab work, etc., and these are to be handled by appropriate clinics, agencies, etc.

IV. Funding

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family service plan (IFSP) on July 1, 2009, this prohibition shall apply on August 1, 2009.

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Regional centers may pay for medical or dental services during the following periods:

a. While coverage is being pursued, but before a denial is made

b. Pending a final administrative decision on the administrative appeal if the family has provided the regional center verification that an administrative appeal is being pursued.

c. Until the commencement of services by Medi-Cal, private insurance or a health care services plan. [Welf. & Inst. Code §4659 (d)(1)(A)(B)(C).

FUNDING STANDARDS
Occupational and Physical Therapy

OCCUPATIONAL AND PHYSICAL THERAPY

Service Code: 772 - Physical Therapy
773 - Occupational Therapy
116 – Early Start Specialized Therapeutic Services

I. Definition

A. Occupational Therapy

i. Occupational therapy is a skilled treatment that helps individuals achieve independence in all facets of their lives. Occupational Therapist assists people in developing the "skills for the job of living" necessary for independent and satisfying lives. (American Occupational Therapy Association (AOTA), 2006).

ii. The role of the occupational therapist includes:

- Administration of developmental and performance skills, screens, evaluations/assessments performed in-home and at school or clinic.
- Formulation of individualized treatment programs and provision of individualized occupational therapy treatments.
- Formulation of recommendations for adaptive equipment and/or adapting the environment and provision of training for usage of adapted equipment.
- Provision of guidance and education to family members and caregivers (AOTA Adapt, 2006).

iii. Occupational Therapists are licensed health care professionals.

B. Physical Therapy

1. Physical therapy means the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical and other properties of heat light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation,

treatment planning, instruction and consultative services. The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions.

The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease. (Physical Therapy Registration Act.)

The role of the physical therapist is a licensed health care professional who evaluates an individual's physical status, establishes a plan of care and goals, then administers treatments to promote optimal health. Physical therapists seek to relieve pain, improve the body's movement and function, maintain cardiopulmonary function, and limit disabilities resulting from injury or disease.

C. Occupational and physical therapy services include evaluation and assessment using standardized or non-standardized tests, specialized tests and clinical observations which include the following:

- planning treatment programs with specific goals.
- implementing the treatment/intervention program (using various therapeutic media and approaches.
- devising or ordering adaptive equipment.
- consulting with appropriate professionals and family members.
- monitoring OT/PT programs vendored by SCLARC.

D. Occupational therapy and physical therapy may be provided as:

1. Direct service – the therapist has the primary responsibility for evaluating and/or assessing programs to achieve specific goals.

2. Indirect service is a consult to another professional or parent/caregiver and/or screening of the consumer. Monitoring - periodic checking/evaluating to ensure that skills progress or that skills do not decline.

   a. Consultation - Case review by OT/PT clinician in order to make recommendation for testing, treatment and referral.

E. Occupational Therapy and Physical Therapy are provided by:

1. California Children Services (CCS) for eligible consumers.

2. Home health agencies such as the Visiting Nurses Association (VNA).

3. Individual therapists vendored by the Regional Center and/or Medi-Cal or private insurance.

4. Some public school systems (to non-CCS consumers), e.g., LAUSD Therapy Services Unit and Downey Unified School District Therapy Services.

5. Private practice therapy clinics, managed care and hospital-based clinics.

II. Criteria

A. SC's are to refer consumers to SCLARC OT/PT consultants for evaluation, assessments or consultation regarding the following concerns:

1. Gross and fine motor skills
2. Developmental status
3. Postural responses (e.g. reflexes, equilibrium reactions)
4. Neurological functioning
5. Sensory-motor functioning
6. Self-help skills
7. Pre-vocational skills
8. Social emotional
9. Sensory processing, sensory modulation and regulation
10. Oral-motor, oral-sensory and feeding skills
11. Play skills

B. SC should complete and send a referral form with pertinent records (i.e. most recent medical, previous therapy reports, etc.) to the Physical Therapist or Occupational Therapist Consultant. After the case review, the PT/OT Consultant will make recommendations regarding referral and type of services that are necessary.

C. Consultants either perform or refer out for the necessary evaluations/ assessments in order to; determine the need for treatment/ intervention, determine a specified period of time for intervention, determine the need for adaptive equipment, determine the need for OT/PT to provide therapy in the home, school or clinic and provide parent/caregiver education and instruction for the development of a home intervention program.

III. Procedure

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WIC § 4659 (d) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not purchase medical or dental services for a consumer three years of age or older unless the regional center is provided with documentation of a Medi-Cal, private insurance, or a health care service plan denial and the regional center determines that an appeal by the consumer or family of the denial does not have merit. If, on July 1, 2009, a regional center is purchasing the service as part of a consumer's IPP, this provision shall take effect on August 1, 2009. "…Regional centers may pay for medical or dental services during the following periods:

A. While coverage is being pursued, but before a denial is made

B. Pending a final administrative decision on the administrative appeal if the family has provided the regional center with verification that an administrative appeal is being pursued.

C. Until the commencement of services by Medi-Cal, private insurance or a health care services plan. [Welf. & Inst. Code §4659 (d)(1)(A)(B)(C).

A. Referrals are to be made to generic resources. All possible funding should be explored. Letters of denial from a generic resource(s) and documentation of the appeals processes are to be submitted to Regional Center for consideration of funding services.

Parents must obtain a prescription for OT/PT services from the child's primary physician.

a. If SCLARC funds OT or PT services, the authorization may not exceed 6 months with reassessments every three to six months.

b. Evaluations, progress reports, discharge summaries and other pertinent records are to be reviewed by the OT or PT Consultants.

c. Initial evaluations, progress reports, discharge summaries and other pertinent records should be reviewed by the Occupational and/or Physical Therapy Consultants, as appropriate.

d. A prescription for occupational therapy or physical therapy from the consumer's primary physician is required by most funding sources (e.g. Medi-Cal, CCS, SCLARC, etc.).

IV. Alternative Funding Resources

A. Generic Resources such as; CCS, private insurance, Medi-Cal/Medicare, CHAMPUS, school district and Head Start, are to be explored prior to authorization of Regional Center funding.

B. Consumers under the age of 21 with a medically eligible condition are to be referred to CCS or other generic resources for therapy services.

C. School age children who require OT/PT services in order to benefit from their educational program need to request and obtain services through the IEP process.

D. Consumers receiving therapy from CCS, or on an outpatient basis from Children's Hospital of Los Angeles (CHLA), LAC-USC, Rancho Los Amigos may not receive therapy from Visiting Nurses Association (VNA) or another home health agency at the same time.

Attachment

California Children Services
Medical Eligibility for the Medical Therapy Program

A. There are two separate groups of children served in the Medical Therapy Program.

1. Children with diagnosed neuromuscular, musculoskeletal or muscular disease.

2. Children below two years of age who demonstrate neurological findings that suggest high probability of a physical disability but who have no obvious or visible diagnosed neuromuscular, musculoskeletal or muscular disease.

B. Children with the following diagnosed conditions are eligible:

1. Cerebral palsy, a gross non-progressive neuromuscular disability of early onset, resulting from a pathological lesion in the brain, manifested by the presence of one or more of the following findings:

   a. rigidity or spasticity

   b. hypotonia with normal or increased deep tendon reflexes (DTRS) and exaggeration of or persistence of primitive reflexes beyond the normal age

   c. ataxia (incoordination of voluntary movement, dysdidysdia-dochokinesis, intention tremor, reeling or shaking of trunk and head, staggering or stumbling, and broad based gait)

2. Other neuromuscular diseases that produce muscle weakness and atrophy such as poliomyelitis, myasthenias, muscular dystrophies.

3. Chronic musculoskeletal disease, deformities or injuries such as osteogenesis imperfecta, arthrogryposis, rheumatoid arthritis, ampulation, contractures resulting from burns.

Attachment
California Children Services
Medical Eligibility for the Medical Therapy Program

C. Children below two years with a high probability of a physical disability as described in B are eligible when two or more of the following neurological findings are present:

1. Exaggerations of or persistence of primitive reflexes beyond the normal age (corrected for prematurity).

2. Increased DTRs (3+ or greater).

3. Abnormal posturing.

4. Hypo tonicity with normal or increased DTRs in infants below one year of age. (Infants above one year must meet criteria described in B.1.b.).

5. Asymmetry of neurological motor findings of truck and/or extremities.

CCS services stop at the consumer's twenty-first birthday. As a consumer approaches 19 years of age, make sure that all equipment needs have been explored **PRIOR TO** their twenty-first birthday.

Effective July 1, 2009 Notwithstanding any other provision of law of regulation to the contrary, Regional Centers shall not purchase any services that would otherwise be available from Medi-Cal, the civilian health and medical programs for uniform services, in home support services, California Children's Services, Private insurance or a health care service plan when a consumer or family meets the criteria of this coverage but chose not to pursue that coverage

California Children Services
N.L. 39-1290
12/10/90

FUNDING STANDARDS
OT & PT Services Utilizing
Sensory Integrative Techniques

OT & PT SERVICES UTILIZING SENSORY INTEGRATIVE TECHNIQUES

Service Code: 772 – Physical Therapy
773 – Occupational Therapy

I. Definition

A. Sensory integration - is the neurological process of organizing and processing sensations for use. The "use" may be a perception of the body or the world, an adaptive response, a learning process or the development of some neural function. The theory of sensory integration, the assessment and diagnosis of sensory integrative dysfunction and the utilization of sensory integrative procedures in OT or PT was developed by A. Jean Ayres, Ph.D., OTR. Based on her theory, the integration of the sensory systems including tactile, proprioception, kinesthesia, vestibular, visual and auditory systems provide the foundation for the development of higher level perceptual skills, contributing to the end products of abstract thinking, self-confidence, lateralization of function and academic learning. The perceptual processes basic to learning elementary academic skills are dependent on sensory integration at the brain stem level.

B. Sensory integrative dysfunction - means that the brain is not processing or organizing the flow of sensory information in a natural, efficient manner and thus, does not give the individual good, precise information about themselves or their world. Without efficient processing of and organizing of sensory input, behavior and interaction with others and the environment may be maladaptive.

C. OT or PT utilizing sensory integrative procedures (or sensory integrative therapy) is a neurophysiologically based treatment approach using regulated multisensory input to improve neural processing and to promote an integrated pattern of adaptive responses. The regulated multisensory input focuses primarily on the somato-sensory (tactile, kinesthetic and proprioceptive) and vestibular systems. The OT or PT uses equipment and activities so that the child will interact in a natural, spontaneous and fun way. Active motoric participation is important to the integrative process because of the modifying and organizing effects of sensory input

and a feedback mechanism. However, the motor skill is neither the objective nor the most important end product of treatment. The goal is to strengthen neural integration on a subcortical level especially the neural integration that underlies learning and behavior via sensory stimulation.

II. Criteria

A. Children between 4-10 years of age with suspected/identified sensory integrative dysfunction may be referred. They may be children with learning disabilities (in addition to their developmental disability), Autism, mild Cerebral Palsy or mild/borderline retardation. For older children who are having difficulties in the classroom, to engage in playground/P.E. activities, or to perform daily functional tasks, and the child is in special education placement, the parent may request an OT evaluation and/or therapy services as a related service on the IEP. Some school districts will obtain these services, but the intervention must be of educational benefit to the child and the child must be ineligible for CCS services. It may require fair hearing procedures. Consult with the OT and Education Specialist for assistance.

B. In some instances younger or older children may be referred. If there is suspected or identified sensory processing/sensory integrative difficulties which are affecting the child's ability to learn, play and perform functional tasks, a referral may be made to a generic resource.

C. Consumers are to be evaluated by a qualified professional (i.e. an OT certified in the administration and interpretation of the Sensory Integration and Praxis Tests (SIPT).

D. If treatment is indicated, a therapy prescription must be obtained.

E. Treatment may be provided by qualified occupational or physical therapists via:

1. Private practice Clinics
2. CCS/MTU
3. Medi-Cal
4. Regional Center
5. School Districts

F. SCLARC authorization to fund treatment is to be given for not more than six months at a time. Total treatment time should not exceed two years. Extensions will be considered on a case by case basis.

G. The consumer is to be reassessed every three to six months.

H. Initial evaluations, progress reports and discharge summaries are to be reviewed by the OT Consultant.

I. Occasionally, group OT sessions may be indicated as a transition from individual OT. This is intended to provide socialization with peers as well as sensory processing activities. Referrals must be screened by the OT Consultant.

III. Procedure

If a child is suspected of having sensory integrative difficulties (that are beyond what could be attributed to the developmental disability):

A. Service Coordinator should initiate phone/direct consultation with OT Consultant to determine whether assessment or therapy may be indicated.

B. Consultant to review the case records (recent medical report, psycho-educational assessment, etc.).

C. Phone consult with parent/caregiver, teacher and/or home/school visit may be indicated.

D. If child is in special education, parent may request therapy services through the IEP process and the therapy consultant available to the school district.

E. Service Coordinator and SCLARC Consultant may assist with the IEP process and appeals/fair hearing process as necessary.

F. If the child has a CCS eligible condition, a referral should be made to CCS as outlined in the previous OT/PT guidelines.

G. If services are denied by the school district and/or CCS, and the family has health/medical coverage, a referral can be made to an appropriate clinic and authorization can be requested (e.g. CHLA, Medi-Cal, managed care, etc.)

H. If consumer is denied PT and/or OT, the denial letter along with appeal of denial (if applicable) from private insurance or health care plans must be presented to SCLARC Service Coordinator. WIC §4659(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service

that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009.

In order to achieve the stated objective of a consumer's Individual Program Plan (IPP), SCLARC shall, pursuant to the individual program plan, consider all of the following when selecting a provider of consumer services and supports… The cost of providing services or supports of comparable quality by different providers, if available, shall be reviewed, and the least costly available provider of comparable service, including the cost of transportation, who is able to accomplish all or part of the consumer's individual program plan, consistent with the particular needs of the consumer and family as identified in the individual program plan, shall be selected. In determining the least costly provider, the availability of federal financial participation shall be considered. The consumer shall not be required to use the least costly provider if it will result in the consumer moving from an existing provider of services or supports to more restrictive or less integrated services or supports. [Welf. & Inst. Code §4648(a)(6)(D)]

Regional centers may pay for medical or dental services during the following periods:

i. While coverage is being pursued, but before a denial is made

ii. Pending a final administrative decision on the on the administrative appeal if the family has provided to the regional center verification that an administrative appeal is being pursued.

iii. Until the commencement of services by Medi-Cal, private insurance or a health care services plan. [Welf. & Inst. Code §4659 (d)(1)(A)(B)(C).

FUNDING STANDARDS
Therapy Services - - Equipment

THERAPY SERVICES -- EQUIPMENT

Service Code: 725 - Durable Medical Equipment Dealer

I. **Definition**

A. Various types of equipment may be needed to assist the consumer with positioning, mobility and functional activities.

1. Assistive devices include equipment which positions, stabilizes, supports, or corrects alignment in order to improve posture, increase mobility and prevent deformity. These include wheelchairs, travel chairs, crutches, walkers, splints and braces (orthotic devices).

2. Adaptive devices include equipment which has been designed for or adapted to the disabling condition in order to allow increased independence in functional and self-help skills. Examples include radial deviated spoons, reachers, raised toilet seats, plate guards, etc.

3. Prosthetic devices include equipment designed to replace a missing body part for cosmetic and/or functional purposes. Examples include a myoelectric hand, artificial limb, above-elbow prosthesis, etc.

B. Services include assessment by an occupational therapist or physical therapist to determine need for and what type of equipment, ordering or design the equipment, instruct consumer/family how to use the equipment, maintain and repair and periodically monitor the equipment.

II. Criteria

A. Consumers may be of any age depending upon their need and purpose for the equipment. Need for equipment must be related to the developmental disability. Equipment may be indicated for:

1. Consumers with physical deformities and limitations (i.e., scoliosis, thumb-in-palm deformity, contractures, etc.) that can be attributed to their developmental disability.

2. Consumers who have potential for increased independence in mobility and functional and self-help activities, but cannot perform without some assistance (i.e., persons with CP, hemiplegia, myelomengiocele, muscle weakness, etc.).

3. Consumers with medical or functional necessity (i.e., transportation for non-ambulatory child, post-surgical treatment, etc.).

III. Procedure

A. If a CCS eligible consumer is in need of CCS eligible equipment, refer the consumer to the CCS Medical Therapy Unit (MTU) or fill out a CC-100 Program referral as appropriate for evaluation and ordering. (Refer to CCS guidelines)

B. If a non-CCS eligible consumer is in need of equipment, request medical (i.e. orthopedic) and occupational therapy/physical therapy evaluations as appropriate. All equipment referrals are to be screened by the occupational or physical therapy consultant.

C. Regional Center funding is not considered until CCS, insurance and/or Medi-Cal denials have been obtained. All possible sources of funding must be explored. WIC §4659(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009.

D. Obtain detailed prescription from the consumer's primary physician which should include reason for therapy or equipment. Refer to occupational/physical therapist or physician consultant for assistance.

E. A preliminary visit to the Mobility Clinic (site or school visit) to assess needs and possible types of equipment, a return visit with the equipment vendor to try equipment and for additional assessment, and a follow-up visit upon delivery to check fit, instruct consumer and family on use, etc., are necessary. (This is mainly for wheelchairs, lifts, bath seats, etc.).

F. Prosthetic and orthotic devices must be fabricated by vendors certified in these areas. Some splints can be fabricated by a vendored occupational therapist or physical therapist, or the CCS or hospital-based therapists.

G. Adult consumers who were previously eligible for CCS should receive follow-up after age 21 by a neurologist, orthopedist, or appropriate clinic (e.g. Rancho Los Amigos, Orthopedic Hospital, etc.) to monitor status and equipment needs.

H. Consumers who reside in licensed community care facilities, ICF-DD and skilled nursing facilities, etc., should receive evaluation from appropriate consultants at the facility.

FUNDING STANDARDS
STROLLER PROCUREMENT

Adaptive Stroller Procurement

Service Code: 725 - Durable Medical Equipment Dealer

I. Definition

An adaptive stroller is a lightweight mobility devise that may be considered an option instead of a manual or power wheelchair. There are many factors that assist a clinician in determining a consumer's mobility device including but not limited to positional needs of the consumer, structural/postural abnormalities, growth of the consumer and age-appropriateness.

Equipment shall position, stabilize, support, and correct alignment to improve posture, increase mobility and prevent deformity.

Durable Medical Equipment (DME) will address the needs of the consumer. Needs of the consumer's family may be met coincidentally, but those needs are not a reason for direct funding. Services or equipment which duplicates existing services will not be purchased.

II. Criteria

South Central Los Angeles Regional Center may purchase a stroller under the following circumstances:

A. In all cases, service equipment requests will be reviewed by the Allied Health Team (PT/OT) and the consumer needs to attend the Mobility Clinic for appropriate measurements and recommendations.

B. The consumer, parent or care provider should submit an OT or PT assessment documenting the medical necessity/ need for a stroller.

C. A denial letter from a publicly funded program or a private insurance healthcare service plan needs to be submitted to the regional center.

D. A prescription is required and must be provided to the OT and/or PT Consultants. The prescription must include physician rationale for stroller instead of a wheelchair based on "medical necessity."

E. OT and/or PT Consultants will review records, consumer status, medical reports and other relevant information and screen the consumer for appropriateness of the referral based upon a medical necessity.

F. Request for a stroller may result in the denial if the stroller is not justified as a "medical necessity" for the consumer. The request for a stroller may result in the denial if:

   a. The stroller is duplicating or serving the purpose as the existing primary adaptive equipment for positioning and mobility.

   b. Request for a stroller is for the use of transporting consumer short distances.

   c. The stroller is for the benefit of the parent/conservator, and does not serve a medical necessity of the consumer.

III. Procedure

A. If a CCS eligible consumer is in need of CCS eligible equipment, refer the consumer to the CCS Medical Therapy Unit (MTU) or fill out a CC-100 Program referral as appropriate for evaluation and ordering. (Refer to CCS guidelines)

B. If a non-CCS eligible consumer is in need of equipment, request medical (i.e. orthopedic) and occupational therapy/physical therapy evaluations as appropriate. All equipment referrals are to be screened by the occupational or physical therapy consultant.

C. Regional Center funding is not considered until CCS, insurance and/or Medi-Cal denials have been obtained. All possible sources of funding must be explored. WIC§4659(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part

of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009.

D. Obtain detailed prescription from the consumer's primary physician which should include the reason for therapy or equipment. Refer to occupational/physical therapist or physician consultant for assistance.

E. Adult consumers who were previously eligible for CCS should receive follow-up after age 21 by a neurologist, orthopedist, or appropriate clinic (e.g. Rancho Los Amigos, Orthopedic Hospital, etc.) to monitor status and equipment needs.

FUNDING STANDARDS
Therapy Services - Equipment
Wheelchair Ramps & Van Lifts

THERAPY SERVICES - EQUIPMENT
WHEELCHAIR RAMPS & VAN LIFTS

Service Code: 725 - Durable Medical Equipment Dealer
021 - Vehicle Modification and Adaptation

I. **Definition**

A. A wheelchair ramp allows access in and out of a home or building, in and out of certain vehicles, etc. Ramps may be portable, modular or telescoping. Hand rails may be provided to allow for independence and safety, or the parent/care provider may push the individual if he/she is dependent in mobility. Ramps are less expensive and usually do not require major repair.

B. A hydraulic van lift allows entry into and exit from a van without leaving the wheelchair. It may be operated by the individual (if capable) or by the parent/care provider. It may be installed at the side or the rear. For persons in wheelchairs who can drive, it allows complete access and independence for mobility and travel. For persons who are dependent and/or severely disabled, and difficult to manage, it allows the parent/care provider a safe means of transportation without taking the individual out of the wheelchair. Van lifts and conversions are very expensive and require maintenance and occasional repairs.

II. Criteria

A. Purchase of a wheelchair ramp may be appropriate when:

1. Denial letter and documentation of the appeals process from all possible funding source (e.g., CCS, private insurance and other governmental agencies, etc.) for the requested ramp is received.

2. WIC §4659(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health

and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009.

3. Another effective and safe ramp is not available for the home or the auto. Existing law requires that SCLARC provide the consumer with the least costly equipment that will meet the needs of the consumer and comply with safety standards.

4. Individualized OT/PT evaluation at the consumer's residence for residential ramping or at the site of the parked auto for auto ramping has been completed and a recommendation has been made that the ramp is indicated for ease of access and/or safety for consumer and/or caretaker.

5. The DME vendor and OT/PT clears the residence and/or auto for ramping (e.g., no evidence of architectural barriers, no evidence of environmental barriers, safety, and etc.).

B. Purchase of a hydraulic van lift may be considered by the IDT when the following conditions exist:

1. The parent/care provider has a van in good working condition.

2. The consumer weighs over 55 pounds.

3. The consumer has a physical condition (e.g., severe athetoid movements), which makes it difficult to safely push themselves up or down a ramp.

4. The consumer requires a two-man lift technique for transfers or the use of a lifter or other equipment for daily management at home.

5. The parent would otherwise not be able to maintain the consumer at home.

6. The consumer has an electric wheelchair or non collapsible wheelchair.

7. The consumer would be able to independently operate a van if it were modified with a hydraulic lift.

C. Other conditions which warrant consideration may include:

1. The parent/primary caregiver has a health problem (e.g., arthritis, heart condition, muscle weakness, chronic back injury, etc.).

2. The parent/caregiver has sole responsibility for the consumer's care; no other support/assistance is available and alternatives have been exhausted.

3. There is more than one non-ambulatory person in the home.

4. There are several children under five years of age in the home.

III. Procedure

A. If a wheelchair ramp or hydraulic van lift is being considered, a comprehensive assessment and/or home visit by an occupational or physical therapist (e.g., CCS therapist, hospital therapist, Regional Center vendored therapist, SCLARC consultant, etc.) and medical equipment specialist is necessary to explore all options and determine what is appropriate. All referrals are to be screened by the OT and/or PT Consultant.

B. Obtain a detailed prescription, including diagnosis and medical necessity/justification, from the consumer's primary physician. The prescription for the van lift must include a wheelchair tie down system. Also, the consumer's wheelchair must have a seat belt.

C. Regional Center funding is not considered until written denials from CCS and/or Medi-Cal, HMO, Department of Rehabilitation, private insurance or any other generic resource have been obtained. The Department of Rehabilitation has funded van lifts for consumers who are able to drive their vans.

D. The hydraulic/van lift may not exceed the cost of the fair market value of the van being converted.

FUNDING STANDARDS
Audiology Services

AUDIOLOGY SERVICES

Service Code: 706 - Audiology

I. **Definition**

Audiology refers to the science and means by which an individual hears. The ear has three parts:

1) the external ear (ear lobe, ear canal, and ear drum);
2) the middle ear (three small ear bones, the Eustachian tube, three semi-circular canals controlling balance); and
3) the inner ear (cochlea, and auditory nerve leading to the central auditory pathways).

A hearing loss can be either congenital or acquired. Some are temporary which are medically treatable, and others are permanent possibly requiring augmentation such as a hearing aid. Hearing loss should be objectively assessed and diagnosed by a licensed/certified audiologist typically found in large medical facilities, Ear, Nose and Throat (ENT) offices, and private full-serviced speech and hearing clinics.

II. Criteria

A. There are some conditions that make younger children more at risk for hearing loss (temporary or permanent) including recurrent middle ear infections, meningitis, Down syndrome and cleft palate, to name a few. Having routine hearing screenings during the formulative years of language and speech development is critical.

B. Consumers who do not localize or orient to sound or voice presented at comfortable speaking levels, or consumers requiring sound or voice to be excessively loud should be referred.

C. Consumers wearing hearing aids may require periodic hearing aid evaluations to check the effectiveness of the hearing aid(s) for consumer use. Strange noises coming from the hearing aid may be signs of malfunctioning and should be brought to the attention of an audiologist.

III. Procedure

A. Many health plans, private medical insurances and Medi-Cal cover audiology services for children (infants/toddlers, preschool and school-aged). The family should contact the child's primary care physician for a referral when there are questions about hearing.

B. John Tracy Clinic provides free hearing screenings for children 0 – 6 years. If a child cannot be assessed via traditional behavioral audiometry procedures, a referral may be suggested for special audiological testing in a hospital setting.

C. School-aged children may be referred to the school nurse for a hearing assessment via an educational audiologist.

D. Consumers with severe cognitive or developmental conditions may not respond to traditional behavioral audiometry procedures, and may require special audiological testing. A physician's referral is required.

E. Audiology and hearing aid services for adults (over 21 years of age) with Medi-Cal have been excluded from coverage under the "Optional Benefits Exclusion" policy effective July 1, 2009. Adult consumers with private insurance should review their individual policies for coverage of audiology and hearing aid services and utilize benefits in this area if available.

F. California Children's Services (CCS) will cover the purchase of hearing aids for children under the age of 22. They require a complete audiological assessment report from one of their approved vendored panelists (almost all major hospitals qualify) and a report of medical clearance from an ENT Specialist or a primary care physician indicating that the hearing loss is not a medically treatable condition. The family must undergo the usual CCS financial review as well.

G. When no generic resource is available to the consumer, a request for audiology or hearing aid services via regional center funding may be considered.

FUNDING STANDARDS
Speech and Language Services

SPEECH AND LANGUAGE SERVICES

Service Code: 707 – Speech Pathology
116 – Specialized Early Intervention Services

I. Definition

A speech disorder consists of delays or abnormalities in articulation (speech production), voice (volume, pitch, and tonal quality), or fluency derived from different causes. A speech disorder can be a sole condition or a part of a developmental disability such as Mental Retardation or Cerebral Palsy.

A language disability can be caused by delayed acquisition or impaired development in the processes associated with learning to understand, verbalize and/or write the code/symbols associated with speaking and communicating meaningfully. A language delay or disorder can be a sole condition, a part of a more generalized developmental delay, or disabilities such as Autism and Mental Retardation.

Speech and language services include the assessment, evaluation, and/or treatment of delays and impairments associated with speaking and communicating. Individuals with developmental delays or disabilities can present with communication deficits of various degrees and severities. Intervention in the area of speech and language (speech therapy) may or may not improve one's condition as individual characteristics and conditions influence prognostic outcomes. While intervention may focus on developing parameters of oral speaking, this service may also incorporate other modes of communication (visual systems, signing, etc.) depending on need.

II. Criteria

A. Family of a 0 – 3-year-old consumer who meets criteria for the Prevention Program may receive a speech and language consultation and parent education related to the consumer's status via SCLARC Speech consultant to learn ways to stimulate the consumer's development in this area

B. Family of a 0–3 year-old consumer who meets the criteria for the Early Start Program may receive a speech and language

assessment to determine consumer's present level of functioning and for recommendations as a part of the assessment and coordination activities of the Early Start Program. Utilization of Early Start funds for treatment/therapy, however, may be accessible following the family's use of available generic resources or by providing SCLARC with an official disclaimer stating the reason why the consumer cannot access the service via the available resources.

C. A regional center consumer between the ages of 3–21 years old may receive either a speech and language assessment or consultation review as a second opinion to service denial made by the Local Educational Authority (LEA, or school district) when an appeal is being pursued via that agency.

D. A regional center consumer 22 years old and above may receive a speech and language consultation review via SCLARC Speech consultant for recommendations. Given the underlying nature/cause for delay/disorder associated with the developmental disability and the underlying assumption that a reasonable amount of speech and language growth and development should have taken place by this time, there may be no need to fund an assessment. Consumers with more limited communication abilities associated with a particular developmental disability may need to be assessed for alternative communication systems. (See funding standards for Augmentative/Alternative Communication (AAC) systems.)

III. Procedure

A. Families should be encouraged to discuss concerns about their young child's speech and language growth and development with the primary care physician during pediatric visits and obtain a prescription for evaluation and therapy.

B. Generic resources should be pursued first as regional center is the payor of last resort. Early Start consumers may be recommended for assessment or evaluation during the eligibility team review or a clinical review by the speech-language specialist. SCLARC-funded speech therapy for Early Start consumers may be authorized when there are no generic resources available or a formal disclaimer denying services has been provided. Service code 116 is an Early Intervention service code that should only be used for the 0–3 year population when resources are limited or unavailable, and can only be used with an approved vendor.

C. For consumers ages 3 – 21 years of age, refer to the Local Educational Authority (LEA) for assistance as Language and Speech Services (LAS) are included in educational services under federal and state special education laws. The referral may start with a screening to determine if further assessment is needed. Families may appeal decisions made in this area with the LEA but regional centers cannot supplant these services as the jurisdiction deemed responsible for delivery of these services is the LEA.

When the school district determines that a consumer does not qualify for related language and speech services, the family should request an explanation of that decision directly from a knowledgeable member of the Individual Educational Plan team, rather than request SCLARC's consultant to speculate about another's decision. Updated assessments and/or IEP's covering the last two school years will be beneficial to complete the review process. Regional Center is payor of last resort and assistance via speech therapy must be sought first through generic resources (e.g., healthcare plans, private insurances, CCS, Medi-Cal, etc.). Consumers and families may obtain a referral for speech therapy through the primary care physician, if a health care plan or insurance is involved.

FUNDING STANDARDS
Augmentative/Alternative
Communication Services

AUGMENTATIVE/ALTERNATIVE COMMUNICATION

Service Code: 642 - Interpreter
725 – Durable Medical Equipment

I. Definition

A system of communication that is different from traditional spoken language and beneficial toward enhancing expression of ideas when speech and language skills are delayed, disordered, or significantly compromised. These systems may vary from use of sign language, total communication, picture-based/visual systems, to technology-based speech generating devices.

1. Sign Language and Total Communication

Service Code: Interpreter – 642

Sign language is a system of manual symbols used to convey ideas. It was originally used with the deaf population but has been beneficial in developing meaningful communication in at-risk and developmentally disabled individuals. American Sign Language (ASL) is more commonly used, but other more grammatically-based sign language systems are also used. Total communication is the combined use of spoken language and sign language.

2. Picture-based Systems

Pictures or photos are used to assist an individual in communicating their wants, ideas and needs. Picture systems can range from communication boards and books to assist with basic low-demand communication needs to a more dynamic system, such as Picture Exchange Communication System (PECS), to meet various functional communication needs. Picture selection is based on the individual's unique interests and needs, and may be different depending on setting.

3. Technology-based Speech Generating Devices (aka: non-oral devices)

Service Code: 725 - Durable Medical Equipment Dealer

These systems range from inexpensive low-tech speech generating devices that can meet a variety of basic communication needs for mild – moderate disabled individuals to very expensive high-tech devices that can meet a full-range of novel conversational needs for individuals ~~of~~ with near average intelligence but who exhibit ~~with~~ significant motor-speech impairments compromising verbal expression.

II. Criteria

A. Consumer has a need for a communication system when traditional oral speech development has been significantly compromised by disability or the consumer has had limited success developing or using traditional oral speech following some time in speech therapy.

B. Consumer has demonstrated success in using a non-tech *AAC* system and has transitioned to an adult day program and/or residential facility where there may be a need to have that system used again.

C. Consumer has demonstrated several years of success using a technology-based speech generating device while attending school and continues to need such a device upon exit because it is school property and must be returned.

III. Procedure

A. WIC §4659(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's Individual Program Plan (IPP), the prohibition shall take effect on October 1, 2009.

B. Non-tech systems such as sign language and picture-based systems are usually tried first due to their low cost and as a beginning strategy

to establish basic communication. The consumer's circle of support may desire some training and should start with the professional using the system with the consumer.

C. Consumer's ages 3-21 years may be referred through the special education/IEP process for AAC assessment and evaluation. Sometimes non-tech systems (sign language, total communication, picture-based systems) are incorporated as strategies into the IEP for classroom instruction or communication development under the communication/language domain. However, when a speech generating device is being considered, a formal assessment where the consumer is tried on various devices is required with a report of the findings and recommendations. When a speech generating device is recommended or used, it is on a "loan" basis to the student and considered school property. It must be returned to the school district when the student exits the program. The consumer's circle of support may desire some training in the use of the device and should start with the professional(s) using the system with the student at school.

D. Consumers who have demonstrated success in using a speech generating device and will require a similar communication system upon exiting school should prepare for having a personal speech generating device purchased at least 1.5–2 years before exiting high school due to the requirements involved with funding. The school AAC Specialist following the student should re-assess the student using the standard protocol required by companies in the industry to purchase a device and submit for funding via student's insurance. The family physician may be required to write a prescription or referral for funding and this can be discussed with the family by the AAC Specialist conducting the assessment.

E. CCS eligible consumers with a neurogenic disability (e.g. Cerebral Palsy) should have the AAC report and required paperwork for purchase of a speech generating device submitted to them 2 years before CCS eligibility expires (age 21). This should be discussed at an annual IEP and coordinated with the CCS Liaison.

F. In the absence of generic resources (Medi-Cal, private insurance, school district and CCS,) a consumer may have their case records reviewed/screened for AAC system by SCLARC's Speech and Language Specialist. The SC should forward the case record with updated, relevant information about the consumer's status/functioning (IPP/IFSP, medical, psychological/developmental, speech-language, and educational records) for a recommendation. Also, attach any formal disclaimers denying purchase of the speech-generating device desired.

BEHAVIORAL INTERVENTION

Service Codes: 620- Behavior Management Consultant
102- Individual and Family Training (Behavior Intervention)

I. Definition

Behavior Modification is the use of learning principles to increase desirable behaviors and decrease undesirable behaviors. It is based on applied behavior analysis, and it involves identifying, measuring and changing those specific behaviors which have been chosen for intervention.

Behavioral Intervention is the application of behavior modification techniques to identify, measure, and change specific behaviors which have been identified as problematic to the individual or others. It is intended to be time-limited. The care providers receive training from qualified behavior consultants and the care providers then carry out recommended behavioral treatment procedures to bring about changes in the targeted behaviors.

II. Criteria

When a regional center consumer exhibits behaviors which put them or others at risk of injury, or if the behavior causes significant distress for the consumer or others, the behavioral intervention services should be considered, along with alternative ways to address the problems, such as counseling or psychiatric services. Behavioral intervention may be provided by training the caregivers in a group setting or by in-home behavioral intervention, which is usually a more intensive option. For both types of intervention, treatment procedures should be based on a functional assessment of the presenting problems and must be carried out by the primary caregiver(s). The professional consultant providing the training must work in partnership with the caregiver(s) to assess the behavior problems, provide training in procedures based on that assessment, assess changes in targeted behaviors and implementation of the procedures and then provide further training and/or revise treatment procedures as necessary. The consultant should gradually reduce involvement over time, with the goal of empowering the caregiver to independently and effectively manage the consumer's behavior.

Behavioral intervention is different from Discrete Trial Training (DTT), which is an educational intervention that is also based on the principles of learning, or Applied Behavior Analysis (ABA). That intervention is used to address communication and other skill deficits characteristic of young children with Autism. It is not a primary modality to reduce serious behavior problems such as aggression and self-injurious behavior. Please see the SCLARC policy on Intensive Early Intervention for Children with Autism for applicability of those procedures and guidelines for the purchase of that service.

A request for purchase of behavioral intervention services/supports is appropriate when it is determined that the service/support will have a positive influence on one or more of the following criteria. It is preferable to make the referral as the problem emerges rather than after problem behavior has resulted in a crisis situation with respect to one of these criteria:

1. Consumer's ability to maintain in-home residence is threatened, or movement to a supported living arrangement is jeopardized by the presence of undesirable behaviors.

2. Consumer's behavior is such that it is likely to evoke potential harm from others. These behaviors may include nuisance behaviors which precipitate abuse from caretakers and/or peers and immature or disruptive behavior in public which may elicit or provoke an attack on the consumer.

3. Consumer's behavior is a danger to themselves or others, including self-injurious behavior, assaultive behavior, destruction of property, criminal behavior, or dangerous, irresponsible behavior (e.g., running into the street, swallowing toxic substances). If one or more of these criteria is not fully met, a less intensive intervention may be recommended.

For emerging and non-severe problem behaviors, group training is the preferred intervention modality. SCLARC provides group training in both Spanish and English languages. Several families with similar problems may learn behavior techniques which may be applied at home. This is a cost-effective method for delivering behavioral services/supports to families/care providers.

One advantage of parent training is that parents in group training sessions often serve as resources and sources of support for each other. This option is particularly recommended for parents of children under the age

of six. Service Coordinators should contact the staff Psychologist or Behavior Specialist regarding referrals.

Government Code section 95020 and Welf. & Inst. Code section 4685, requires consideration of group training for parents for behavioral intervention techniques in lieu of some or all of the in-home parent training component of behavioral intervention services.

III. Procedure

When there is an indication that a consumer needs behavior intervention, the Service Coordinator should consult with the consumer and family and/or caregiver, if appropriate, and discuss with them behavioral intervention, criteria for purchase of this service/support, and alternatives to the purchase of behavioral intervention services/supports. The letter addressed to care-providers to inform them about in-home behavior intervention services should be sent to the family/caregiver. The letter should be dated and co-signed by the Behavior Specialist (via electronic signature) and the Service Coordinator. If the consumer, the Service Coordinator, and (when appropriate) the consumer's family agree, the Service Coordinator shall make a referral for screening to the Behavior Specialist. The Behavior Specialist, the Service Coordinator and the consumer/family will determine what type of behavioral service/support appears most appropriate and whether a referral should be made for psychological/psychiatric services/supports or behavior intervention group training for parents. This screening process should specify the target behaviors, the goals of treatment/supports (which behaviors will be increased and which will be decreased), the relevant IPP objectives and the appropriateness of the type of service/support in relation to the ability of the consumer and family to benefit from behavioral services. This screening process may involve phone contacts with the consumer and/or family and/or one or more visits by the Behavior Specialist to meet the consumer and/or care providers to more fully assess the problems and their maintaining conditions, and to discuss fully with the consumer, provider and/or family these problems and the range of treatment options. At that time, recommendations for brief treatment may be made. The short-term response, both by the consumer and by the provider and/or family, to these recommendations may be used to determine whether vendored behavioral intervention will be worthwhile.

Behavioral services may be available from generic resources. SCLARC may not provide the behavioral services until proof has been submitted that private insurance or the family's health plan do not cover the service. The least costly available provider of comparable services shall be selected if SCLARC funds the behavioral services.

If a written denial from the family's private insurance or health care service plan is received and there is documentation that the denial has been appealed, procedures to initiate in-home behavior intervention may begin.

No behavioral intervention service/support shall be continued unless the consumer or, where appropriate, the family, legal guardian or conservator is satisfied with the service/supports. The consumer/family, guardian, the Service Coordinator and the Behavior Specialist must agree that planned services/supports have been provided and that reasonable progress toward the stated objectives have been made. In general, interventions will not be authorized for more than six months unless a special case is made for the necessity of further treatment. These special cases must be approved by the Regional Center Psychologist, in consultation with the Behavior Specialist, and must be fully staffed and approved by the consumer's interdisciplinary team. The consumer and family or other care provider should be trained to implement and maintain behavior programs and must not become dependent on the behavioral vendor's direct intervention after the authorized periods. All interventions should include procedures for termination of the intervention within the authorization period.

FUNDING STANDARDS
Psychological/Psychiatric
Services/Supports

PSYCHOLOGICAL/PSYCHIATRIC SERVICES/SUPPORTS

Service Code: 785 - Clinical Psychologist
780 - Psychiatrist

I. Definition

Psychological/psychiatric services/supports refer to a variety of psychotherapeutic modalities/interventions which are oriented toward the amelioration/treatment of certain symptoms associated with mental disorders. Some of the more traditional approaches are: counseling, individual therapy, group therapy, family therapy and crisis intervention. The psychological/psychiatric services/supports are only available for consumers found to be eligible under the Lanterman Act.

Mental Disorder - In DSM-IV-TR, a mental disorder is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual which is associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not merely a conflictual relationship between the individual and society. When the disturbance is limited to a conflict between an individual and society, this may represent social deviance, which may or may not be significant, but is not by itself a mental disorder.

II. Criteria

A consumer should be referred for psychological/psychiatric services and supports in instances when they either manifest or are suspected of manifesting symptoms/behaviors which are suggestive of a mental disorder.

III. Procedure

1. Consultation with Staff Psychologist

Consult with the area staff psychologist for clarification regarding the possibility of a differential diagnosis in all instances when there is a question as to whether the presenting problems are a consequence of a behavior problem (which is amenable to behavior management services) or a mental disorder. Behavior intervention may effectively treat manifestations of mental disorders, but other mental health services should also be considered.

2. Accessing Los Angeles County Department of Mental Health (LAC/DMH)

A. Referrals to LAC/DMH should be made in a timely manner when symptoms of apparent mental disorder first surface in order to avoid unnecessary hospitalizations and placement crises.

B. How to Make Referrals:

Referrals should be made to the mental health service facility located nearest to the consumer's residence. However, the location of services may vary according to resource availability, personnel or special needs.

General Information and referral inquiries regarding Los Angeles County Department of Mental Health resources can be accessed by calling (800) 854-7771. Assistance with identifying the appropriate Community Mental Health Centers, as well as the identification of other generic mental health services is accessible via this telephone contact. This service is available 24 hours a day.

C. Crisis and Emergency Referrals:

During instances of suspected psychiatric emergencies, call (800) 854-7771 for 24 hour Crisis and Emergency services. However, be advised that the Psychiatric Mobile Response Team will address crisis and emergency **mental health issues only.** The primary determined factor for PMRT responding is that the consumer must be exhibiting behaviors consistent with W&I Code 5150 criteria.

D. Relevant Consumer Data in Referral Process:

1. Regional Center Service Coordinators (SC) shall provide relevant information and records after informal consent is obtained, and, whenever possible, shall be present on site *(e.g., hospital, residence)* to

assist with assessment and disposition of crisis/emergency cases.

2. The following information would be helpful when requesting LAC/DMH services:

   a. copies of consumer's personal history, diagnostic and treatment records pertinent to both the developmental disorder and mental disorder;

   b. list of all present medications and dosages

   c. name and phone number of current treating physician and/or other professionals.

   d. name and phone number of present care provider, residence and contact person/family.

   e. consumer's legal status (e.g., conservatorship).

   f. present psychiatric symptoms which concerned the referring party and which precipitated the referral, including but not limited to: suicidal, violence to self or others, recent and present sleep and eating disturbances, and any description of behavior changes which prompted the referral.

3. LAC/DMH Crisis Intervention and Emergency Services

   a. Referral Procedures:

      If there is an immediate danger to self or others, or if physical restraints are necessary to prevent injury, call 911.

      When consumer's condition is believed to require mental health intervention, but there is no immediate danger to self or others, consultation with SCLARC Psychiatric Consultant and/or staff Psychologist is recommended for clarification of the consumer's mental status and appropriate referral resources. Upon the recommendation of SCLARC psychiatric consultant and/or staff psychologist, and if feasible, the consumer

should be immediately transported by the nearest mental health center for a psychiatric evaluation. The Regional Center Staff (SC) should never under any circumstances transport the consumer.

The LAC/DMH bears the responsibility for developing an appropriate treatment plan including, if necessary, hospitalization and outpatient services. If necessary, LAC/DMH staff will initiate the 72 hour involuntary hold (Welfare and Institution Code 5150) for Evaluation and Treatment.

b. Method of Resolving Problems Regarding Referral Initiation to LAC/DHM:

1. Contact SCLARC's Mental Health Liaison/Staff Psychologist II or Psychiatric Consultant for assistance in resolving any problematic issues regarding mental health services or resources

NOTE: In the utilization of Los Angeles County Mental Health Services, psychological/ psychiatric treatment must be purchased via Medi-Cal or, alternatively, Short Doyle payment method.

FUNDING STANDARDS
Psychological Re-Evaluation

PSYCHOLOGICAL RE-EVALUATION

Service Code: 785 - Clinical Psychologist

I. Definition

A psychological evaluation refers to a written report that determines the consumer's current functioning in the following areas; cognitive/academic, communication, sensorimotor, social/self-help, and adaptive/behavior and mental health status. It should include level of mental retardation, if any, specific level of developmental disability and other diagnoses as well as appropriate recommendations.

II. Criteria

Initial evaluations are coordinated through the intake unit to determine eligibility. A psychological re-evaluation shall be conducted when it is of benefit to the consumer and not only to satisfy the curiosity of a parent or care provider. Keep in mind that other agencies in the community are periodically re-evaluating our consumers, such as schools, Department of Rehabilitation, Social Security, courts, hospitals, etc. These reports should be requested prior to requesting SCLARC psychologists or vendors to re-evaluate consumers. If no current and/or acceptable psychologicals are available, one will be scheduled with SCLARC vendors.

All regional center consumers must have on file a signed psychological evaluation with an appropriate diagnosis that determines eligibility for regional center services/supports.

All adult regional center consumers need to be re-evaluated on an as needed basis, after consultation with staff psychologists.

Children Under six years of Age:

1. Children who have been labeled "Developmentally Delayed" need to be re-evaluated to determine a definitive diagnosis and continued eligibility for Regional Center services and supports.

2. Any child who has experienced serious trauma of a physical or psychological nature should be re-evaluated yearly until treatment needs are stabilized.

3. All school-aged children (ages 3-21) need to be re-evaluated every three (3) years. School districts are mandated by law to evaluate children in Special Education at least once every three years. Service Coordinators should routinely request copies from the school district.

4. High Risk consumer cases managed by the Early Start Unit should be re-evaluated by age three to determine their eligibility for ongoing regional center services and/or to provide recommendations for referral to community support systems. Frequently reports from developmental programs are sufficient to determine the consumer's status/needs.

School Age Children Over six Years:

1. Children who experience serious behavioral problems and require private or residential school placement are appropriate for referral. The school shall be asked to provide an evaluation first.

2. Children whose parents disagree with a school's evaluation shall be referred for an independent evaluation to help address the parent's contention in developing the IEP or request for different class placement.

3. Individuals who have made substantial progress in school and may no longer be in need of regional center services and supports, and who may benefit more by removal of the labeling associated with regional center consumers, should be re-evaluated before submitting the case file for re-determination of eligibility.

Other Cases Referred for Psychological Assessment Are:

1. Persons who are involved in court or legal proceedings where a psychological assessment could work to their benefit by documenting to the court that the consumer's case is relevant to 1370.1 of the Penal Code, and Welfare and Institution Code 6500, Diversion, probation or parole program. In most cases the court will appoint an independent psychologist to do an evaluation. In such cases a second evaluation by the Regional Center is not necessary, but can be considered.

2. Adults who become involved in serious emotional problems and need referrals to mental health may be appropriate to refer for

psychological evaluation. In most cases the person or agency providing the treatment may want to do their own evaluation.

3. Adults who are changing programs (e.g., state hospital to board and care; board and care to independent living; parent's home to independent living or board and care) may need to be re-evaluated for development of the Person Centered Individual Program Plan (IPP).

4. Individuals who may have a change in their cognitive functioning due to a medical problem i.e. head trauma, stroke, dementia et al.

The above list of situations that determine the need for re-evaluations is not exhaustive. You may have a situation that does not fit any of the above examples and should be explored with a SCLARC staff psychologist regarding appropriate options.

III. Procedure

If you are unable to obtain a current psychological evaluation report from a community agency, consult with the staff psychologist about the specific reason that an updated psychological evaluation might be warranted. If deemed appropriate, the SC should complete and submit the **"Re-Evaluation Assessment Worksheet"** and a current Client Face Sheet to the Intake Secretary for appointment scheduling. Please include a complete statement regarding the reason for the referral with specific issues/questions that you would like the psychological evaluation to address. Please print the name of the SC and extension number on the bottom left line of the form. The Intake Secretary shall e-mail the SC a copy of the appointment letter. Within two days of the scheduled appointment, the Intake Secretary will request the SC to send consumer's case record to the Intake Unit.

RESIDENTIAL PLACEMENT

Service Codes:
910 - Level 2 (Owner Operated) Children
905 - Level 2 (Owner Operated) Adults
920 - Level 2 (Staff Operated) Children
915 - Level 2 (Staff Operated) Adults
910 - Level 3 (Owner Operated) Children
915 - Level 3 (Owner Operated) Adults
920 - Level 3 (Staff Operated) Children
915 - Level 3 (Staff Operated) Adults
915 - Level 4

I. Definition

Residential placement services refer to the provision of direct care supervision and training of consumers by State-Licensed Community Care Facilities which are, if required, vendored by the Regional Center. Training shall mean the delivery of special services by facility staff to consumers during the process of implementing the facility program design and achieving the objectives on the Individual Program Plan (IPP) for which the residential service provider is responsible.

Residential placement services may be purchased for minor consumers who are unable to live in the family home. A description of the residential programs per the Alternative Residential Model (ARM) Service Level and Intermediate Care Facilities (ICF) is as follows:

A. Service Level I (Non-Arm)

A Level I Facility provides basic non-medical board and care and general supervision. There are no quality assurance standards required for this type of facility. However, the facility must meet the requirements of Title 22, Division 6. Providers are not expected to provide any regularly scheduled activities, training or supervision to implement IPP Objectives. Consumers considered appropriate for this level of service include very capable individuals and those who may have additional needs but who have consistently rejected offers of support, training or treatment.

All community care licensed facilities which are approved for Levels II-IV must meet requirements under Title 17 Regulations, Sub-Chapter 4, Residential Services and Quality Assurance Standards.

B. Service Level II (Owner Operated or Staff Operated)

A Level II facility is similar to a homelike family setting where daily activities reflect the pattern of daily living for non-disabled persons of the same chronological age. Consumers considered appropriate for this level of service include, but are not limited to, individuals who require a moderate amount of supervision, support and training to enable them to participate in activities of daily living both at home and in the community. These consumers generally have basic self-help skills and no significant behavior problems.

C. Service Level III (Owner Operated or Staff Operated)

A Level III Facility approximates a homelike setting with a more structured environment in which staff interventions take place in a more highly scheduled and predictable manner. Additional staffing and training requirements are included to ensure that consumers with more intensive needs for supervision, support and training can be appropriately served. Consumers considered appropriate for this level of residential placement programming would include, but not be limited to, individuals who are non-ambulatory, present significant behavior deficits or excesses, or have little self-help ability and require substantial supervision, support and training to enable them to participate in activities of daily living.

D. Service Level IV (Staff Operated Only)

A Level IV Facility provides a highly structured environment in a homelike natural setting uniquely designed to meet the needs of consumers whose behavioral deficits and/or excesses prevent participation in activities of daily living and whose challenges are so significant that they are unable to be met in other residential facilities. Within Level IV are nine rate levels which represent different requirements for consumer-to-staff ratio and consultant hours. Consumers considered appropriate for this service level are individuals requiring highly structured supervision, support and training, intensive staff to consumer support and on-going consultation services to provide direction for the development of consumer IPP and ISP (Individual Service Plan). Specific diagnosis of the individual is not the sole criterion for

recommendation of Level IV services. These consumers have needs for formal behavior management programming.

E. Intermediate Care Facility for the Developmentally Disabled (ICF-DD)

A health facility which provides care and support services to developmentally disabled persons whose primary need is for developmental services and who have recurring, but intermittent, need for skilled nursing services. Capacity is 16 or over. This facility is licensed by the State Department of Health Services and funded by Medi-Cal.

F. Intermediate Care Facility for the Developmentally Disabled - Habilitative (ICF-DD/H)

A 15 bed or less facility which provides essential supportive health care and program training to persons whose primary need is for developmental services, and who have recurring, but intermittent need, for nursing services. This facility is licensed by the State Department of Health Services and funded by Medi-Cal.

G. Intermediate Care Facility for the Developmentally Disabled - Nursing (ICF-DD/N)

A facility which has as its primary purpose the furnishing of 24 hour nursing supervision, personal care, training and Rehabilitative Residential Placement services in a facility with 4-15 beds to medically fragile, developmentally disabled consumers or to consumers who demonstrate a significant delay that may lead to a developmental disability if not treated. This facility is licensed by the State Department of Health Services and funded by Medi-Cal. SCLARC's preference is to place in 4-6 bed ICF-DD/N facilities.

H. Skilled Nursing Facility (SNF)

A health facility or a distinct part of a hospital which provides nursing care and supportive care to consumers whose primary need is for availability of 24-hour skilled nursing care on an extended basis. It provides in-patient care and, as a minimum includes medical, nursing, dietary, pharmaceutical services and an activity program. Capacity: 4 and over. The facility is licensed by the State Department of Health Services and funded by Medi-Cal.

II. Criteria

The Service Coordinator shall obtain a review with recommendations for placement type/level from the Planning Team which must include the appropriate consultant(s), (e.g. Behavioral Consultant for recommendation of Level IV program), prior to submission of funding request. Interdisciplinary team review and recommendations are not required when a consumer is replaced and the facility level/type is the same. Every attempt should be made to effect the initial placement or replacement in the least restrictive type setting. Initial placement or replacement into the most restrictive setting should follow procedures for State Developmental Center Placement (refer to Case Management Guidelines Section 4000 4441-4442). Most SCLARC consumers placed in residential facilities are eligible for SSI/SSA benefits as well as Medi-Cal. These benefits must be applied for prior to placement and this documentation must accompany the placement packet.

III. Alternatives to Purchase of Residential Placement Services

All family resources as well as those of generic agencies should be ruled out as alternatives before SCLARC assumes financial responsibility for residential placement. For example, minors who are identified as victims of child abuse or neglect should be brought to the attention of Los Angeles County Department of Children and Family Services (DCFS) Child Protective Services; consumers who are involved in the criminal justice system may be eligible for placement funding through Los Angeles County Department of Probation, etc.

FUNDING STANDARDS
Supplemental Program Support

Supplemental Program Support

Service Codes:
- 109 Supplemental Residential Program Support
- 110 Supplemental Day Services Program Support
- 111 Supplemental Program Support (Other)

SCLARC may consider additional staffing for consumers residing in community residential settings, participating in day programs or receiving other vendored services in order to prevent their placement in amore restrictive environment. Supplemental support requests will only be honored when alternative intervention/strategies have been exhausted.

Prior to expenditure of regional center funds, the following criteria must be met:

1. The Interdisciplinary Team, including appropriate clinical specialist, must
determine additional staff support is appropriate and necessary and that the consumer's medical and behavioral profiles with regard to placement remain in compliance with Title 17 and Title 22 Regulations.

2. Additional services should not **supplant** the staffing ratio or duplicate services included in the program rate. Inexperienced staff, problems with facility consultants and inappropriate staffing patterns and/or program plans would not constitute good rationale for additional staffing. **There must be evidence that a good behavior intervention plan is in place and is being implemented by the facility/program staff. Problems in these areas should be addressed before considering supplemental staffing.**

3. The residential vendor must submit a copy of the facility's ongoing staff, schedule, the administrator's schedule and the supplemental program support schedule specific to the consumer receiving the additional services. The schedules must be submitted and reviewed before funding is approved.

4. Services must be consistent with IPP or IFSP objectives and provide therapeutic benefits or outcomes. The facility/program staff must show commitment to meeting the special needs of the individual consumer.

5. The individual selected to provide supplemental program support must be qualified and meet minimal training/educational and licensure requirements appropriate to a particular function or discipline.

6. All services are time limited and should not be authorized for more than three (3) months at any one time.

7. Services/staffing related to behavioral intervention must be assessed by the Behavior Specialist and reviewed minimally every 30 days by the I.D. team or until a modified review period is established by the Behavioral Specialist.

8. Services supporting a consumer's medical condition require an initial medical or nursing assessment, consultation with the primary physician and other specialty assessments (nutrition, OT, etc.) when appropriate. Medical conditions must be reviewed every 7-14 days or until a modified schedule is established by the appropriate clinical specialist.

9. The facility/program must maintain detailed documentation **throughout each daily period the consumer is on site or under supervision of facility program staff.** Documentation should include evidence additional staffing is
provided above the facility/program's required staffing level and must describe problems, behaviors, interventions, successes/failures, and correlate with I.D. team plans and recommendations.

10. **Reauthorization of time limited supplemental program support may be considered. In each re-authorization, the following must be submitted and reviewed by the Behavior Specialist:**

1) **Data on target behavior concerns,**
2) **Information of implementation of the behavioral plan by the supplemental staff person(s).**
3) **Plan for fading out use of the supplemental staff. This should include trial periods with a lower (i.e., not 1:1) staff.**

The assigned Service Coordinator must provide initially bi-weekly face-to-face monitoring to ensure compliance with one (1) through eight (9) above. Frequency of monitoring may be modified as determined by the program manager, clinical specialist

FUNDING STANDARDS
Respite Services

RESPITE SERVICES – For the most up to date policy visit:

https://sclarc.org/wp-content/uploads/2025/03/DDS-Approved-In-Home-Respite-Policy-01-15-2019.pdf

~~I. Definition~~

~~Respite services provide intermittent or regularly scheduled non-medical care and supervision of the developmentally disabled minor or adult. All families, at times, experience the need for respite. In most cases, a family of a child with developmental disabilities is able to provide for respite with the assistance of family members, friends or caregivers as they would for a typical child. In circumstances where such resources are unavailable or inadequate to meet the family's needs for respite, the regional center may purchase respite services. Regional center may only purchase respite services when the care needs of the individual exceed those of a person of the same age without a developmental disability.~~

~~Respite is also not intended for use by parents as a substitute for learning to manage their child's challenging behaviors. If a child has challenging behaviors, the parents are *strongly encouraged* to attend a class on parenting the child with special needs or behavior management, as appropriate~~

~~II. Criteria~~

~~In evaluating respite needs, the consumer's care requirements must be considered in relation to what would be expected for an individual at that age. SCLARC is required to consider the family's responsibility for providing similar services to a minor child without disabilities (WIC §4646.4). In addition, Regional Centers must provide or secure family support services that recognize and build upon family strengths, natural supports and existing community resources (W & I Section 4685). When a family's need for respite exceeds the available natural supports or community resources, SCLARC's purchase of respite services may be considered.~~

~~Services are appropriate for parents or primary caregiver when:~~

~~a. The family is providing 7 day-a-week, 24 hour care for the individual in the family home.~~

~~b. Regional center may only purchase respite services when the care~~

needs of the individual exceed those of a person of the same age without a developmental disability.

c. Regional Center will only consider In-Home Supportive Services a generic resource when the approved In-Home Supportive Services meets the respite need as identified in the consumer's IPP/IFSP. (Welf. & Inst. Code § 4686.5, subd. (a)(5)

d. Assist family members in maintaining the consumer at home.

e. Provide appropriate care and supervision to ensure the consumer's safety in the absence of family members.

f. Relieve family members from the constantly demanding responsibility of caring for the consumer.

g. Attend to the consumer's basic self-help needs and other activities of daily living including interaction, socialization and continuation of usual daily routines which would ordinarily be performed by the family members.

h. When indicated as a necessary service on the consumer's IPP/IFSP, respite services may provide support and assistance for the family. Respite services are not intended to meet a family's total need for relief from on-going care or parenting their developmentally disabled child/adult. Respite services are not meant to furnish child care for working parents. It is not meant for the care giver to attend school on a regular basis nor is it to be used for extended day care. It is not meant to provide personal attendant care. (one - on - one aide to assist in activities of daily living, e.g., toileting, dressing, feeding, and bathing, etc.), except as required to provide care to the consumer during the hours of respite.

i. SCLARC will consider IHSS as a generic resource when the IHSS service meets the respite need identified in the IPP or IFSP. When considering IHSS as a generic resource to meet a respite need, the amount of protective supervision provided by IHSS will be reviewed (WIC §4686.5)

j. If regional center assists with funding a social recreation program and respite services, the number of hours of respite may be adjusted. If regional center assists with funding Specialized Supervision and respite services are also funded the number of

respite hours may be reduced.

11. If a child requires specialized medical equipment procedures, such as gastrostomy tube feeding, respite services can also be purchased from in-home respite agencies that opt to provide respite workers training in the care of colostomy, ileostomy and gastrostomy site care. If respite services require an R.N., L.V.N. or a C.N.A., the SCLARC physician or nurse consultants must review the case and document the need for this service. Nurses providing this service will be hired by a vendored agency.

SCLARC will not purchase more than 21 days of out-of-home respite services in a fiscal year nor more than 90 hours of in-home respite in a quarter, for a consumer. The regional center may grant an exemption from the respite limits if it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. (Welf. & Inst. Code § 4686.5, subd. (a)(1)(2)(3)(A))

Early Start Respite

1. Families of children under the age of 3 will not receive funding for "break-in-care" respite services. Generic resources must be pursued (e.g., IHSS).

2. For children under age 3 who have confirmed developmental disability (status 2) are eligible for respite services as defined in Welf. & Inst. Code section 4690.2 and 4686.5.

3. The number of respite hours per month may not exceed 90 hours per quarter unless an exemption has been granted.

4. Respite services may be funded only if the respite is directly related to the disability (e.g., conferences, seminars, parent trainings, etc.).

III. Procedure

1. Service Coordinator will discuss the various natural supports and other existing community resources available to the consumer and his/her family. Families frequently have natural supports available to them, e.g. extended family, siblings, friends, neighbors, co-ops. To the extent that these resources would be available to

assist the family of a non-disabled or high risk individual, they will be considered in the determination of respite needs. In-Home Supportive Services (IHSS), private insurance, Medi-Cal benefits, public school and other community resources must be pursued and utilized to the extent possible before considering respite services. Public school, vocational and day activity attendance may be considered a form of respite for a non-working parent.

2. The need for in home respite must be identified on the IPP/IFSP.

3. A respite agency must be used for all respite services. The agency may be able to provide a staff person if a family is unable to locate a respite provider to be hired by the respite agency, and due to the need of a higher level of care for a consumer with medical needs i.e. a CNA or a LVN as a respite provider. A nursing assessment is required prior to securing funding for an LVN or a CNA respite provider.

4. SCLARC will not purchase more than 90 hours of in home respite in a quarter. If the family is requesting more than 90 hours per quarter, further consultation with the ID team is needed. Documentation will also be needed to demonstrate the intensity of the consumer care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer.

5. Respite needs are expected to change as the consumer/family needs change. Therefore, SC needs to monitor the continued need for respite. The level of respite hours should be adjusted whenever the consumer/family needs change and as additional resources become available to the family.

A. IN-HOME RESPITE AGENCY PROVIDER:

Service Code: 862 – In-Home Respite Services Agency

I. Definition and Criteria

Criteria for respite levels are used in evaluating the family's request for the amount of respite services. The criteria are applied with consideration to the consumer's age, expected behaviors and care needs related to that age. Exceptions may be made on a case-by-case basis by the unit supervisor in conjunction with the ID Team or Department Director prior to the ID Team if it is

deemed emergent and found to be an acceptable alternative.

In-Home Respite services are authorized based on the criteria for the following levels of service:

LEVEL A:

Up to 16 hours per month of respite will be authorized if three or more of the following is present:

A.1 MEDICAL: Consumer has special medical needs, excluding follow up and/or therapy appointments.

A.2 BEHAVIORAL: Consumer's behavior is difficult to manage, e.g., resistance, tantrums. Note however that respite is not a solution for addressing behavioral difficulties and consumers with behavioral challenges should be referred for other services and supports.

A.3 SELF-CARE: Consumer requires supervision or assistance with self-care needs related to the consumer's delay or disability.

A.4 CAREGIVER CONDITION: Caregiver identifies stress related to the consumer's disability.

A.5 FAMILY STRESS FACTORS:

Natural and/or community supports do not meet the full respite needs, or Family is unable to find routine caretaking services due to the consumer's disability or behaviors.

LEVEL B:

Up to 24 hours per month of respite will be authorized if Level A is met and three or more of the following is present:

B.1 MEDICAL: Consumer has medical condition requiring ongoing supervision, i.e., requires equipment periodically, frequent hospitalizations, severe uncontrolled seizures. Requires consultation with SCLARC's Nurse Consultant.

B.2 BEHAVIORAL: Consumer is demonstrating challenging or atypical behavior{s) e.g., aggression, self-abuse, disruptive/destructive behaviors, extreme irritability, atypical behavior related to a psychiatric disorder). (see A.2)

B.3 . SELF-CARE: Consumer requires constant prompting or assistance in two or more self-care areas beyond typical age expectations or physical challenges beyond age expectations (can be considered if consumer is over 18 years of

~~age).~~

~~B.4 CAREGIVER CONDITION:~~

~~Single parent with limited social supports, or~~

~~Adolescent parent (under 18 years of age), or~~

~~Parent has a developmental disability, or~~

~~Caregiver has physical or medical condition causing more difficulty in caring for consumer.~~

~~Geriatric parent with limited supports (over age 70)~~

~~B.5 FAMILY STRESS FACTORS:~~

~~Family is evidencing significant disruption related to the consumer's disability, or~~
~~Caregiver requires hours to attend regular support groups or counseling~~

~~**LEVEL C:**~~

~~Up to 30 hours per month of respite may be authorized by the ID Team if Level B is met and three or more of the following is present:~~
~~Note that respite may be increased temporarily until existing conditions are addressed and returned to previous level once medical, behavioral and/or family stress factors have been addressed and/or resolved.~~

~~C.1 MEDICAL: Consumer is medically fragile and requires care on a periodic basis during the day, e.g. Gastrostomy tube feedings, occasional suctioning, injections or pulmonary treatments. Requires consultation and review with SCLARC nurses.~~

~~C.2 BEHAVIORAL: Consumer is demonstrating ongoing challenging or atypical behavior(s) beyond age-expectations (e.g., aggression, self-abuse, disruptive/destructive behaviors, extreme irritability, atypical behavior related to a psychiatric disorder). Requires Behavioral Assessment~~

~~C.3 SELF-CARE: Consumer has chronic medical and physical needs requiring total care in at least two areas, ie., personal hygiene, eating/feeding, bathing, and dressing. (Can be considered if consumer is over 18 years of age).~~

~~C.4 CAREGIVER CONDITION:~~

~~Caregiver has physical or medical condition requiring frequent treatment, or~~

~~Caregiver has chronic physical or medical issues which are impacting his/her ability to care for the consumer (requires documentation from a health provider). Caregiver is caring for another family member who is elderly or has a chronic and significant medical or mental condition, or Primary caregiver with no assistance experiences sleep disruption for up to two hours every night; this disruption is beyond developmental expectations for the child's age.~~

~~C.5 FAMILY STRESS FACTORS:~~
~~Two or more consumers in the family, or Consumer is at risk of being abused, or Family is receiving counseling for stress-related issues.~~

~~LEVEL D:~~

~~Up to 40 hours per month of respite may be authorized via ID Team if Level C is met and three or more of the following is present:~~

~~D.1 MEDICAL: (No Specific Criteria Identified) - Requires Nursing Assessment~~

~~D.2 BEHAVIORAL: - Requires Behavioral Assessment~~

~~Consumer is exhibiting severe behavioral concerns and is injuring self and/or others, or~~

~~Consumer requires continuous supervision due to disruptive and destructive behaviors.~~

~~D.3 SELF-CARE: Consumer has chronic medical and physical needs requiring total care in all areas, i.e., personal hygiene, eating/feeding, bathing, and dressing. (Can be considered if consumer is over 18 years of age).~~

~~D.4 CAREGIVER CONDITION: Consumer's care significantly interferes with sleep of caregiver; e.g., requires treatment every two hours; feedings take over one hour.~~

~~D.5 FAMILY STRESS FACTORS: Severity and combination of Level C criteria may necessitate additional hours.~~

~~LEVEL E:~~

~~Over 40 hours per month of respite may be authorized via Interdisciplinary Team if Level D is met and three or more of the following is present:~~

~~E.1 MEDICAL: Consumer is medically fragile and requires special care on an hourly basis during the day. Requires Nursing Assessment.~~

~~E.2 BEHAVIORAL: (No specific criteria identified). Behavioral Assessment Required~~

~~E.3 SELF-CARE: Requires Nursing Assessment (i.e., toileting, assistance with ambulation, hygiene and positioning).~~

~~E.4 CAREGIVER CONDITION: (Primary caregiver has life-threatening chronic medical condition which severely interferes with ability to care for consumer, e.g., active cancer requiring treatment, AIDS. Consideration must be given to the amount of direct care needed by the consumer and how the caregiver's health problems functionally impair the ability to meet these needs. Nursing Consultation Required.). Requires Service Coordinator Assessment and Interdisciplinary Team meeting.~~

~~E.5 FAMILY STRESS FACTORS: Family is seriously considering placement and respite hours are necessary to maintain consumer in family home. The severity and combination of Level C and D criteria may necessitate additional hours. Caregiver or family member requires hospitalization or has a severe medical condition requiring special care in a particular month. This should be reviewed monthly with SCLARC Nurse Consultants~~

~~F. TEMPORARY RESPITE INCREASES:~~

~~Families may receive additional one-time respite hours in order to attend a conference or workshop related to the consumer's disability. (Limited to 16 hours/conference; limited to one (1) conference/year, using a Fiscal Year as the period of review).~~

~~In-Home extended care in lieu of out-of-home respite. Regular in-home respite hours for the month will be adjusted on a percentage basis, e.g., if one week of in-home extended care is used, the regular respite authorization will be modified. Funding for in-home extended respite care will be limited to 16 hours/day. The family must make arrangements for eight 8 hours of care/day as expected and would be required in meeting the needs of a typical child. This must be documented on the IPP and the I.D. Notes as part or all of the 15 days of out of home respite services.~~

~~II. Procedure~~

~~1. The Planning Team for respite decisions, at a minimum, consists of the consumer, parent (if appropriate) and service coordinator. Provisions of Level A and B respite services may be authorized by the service coordinator and unit supervisor. Level C, D, and E must be reviewed by the unit supervisor prior to submitting for approval and may be authorized up to a period of one year. Levels~~

~~may be authorized for up to a period of one year if approved by the unit supervisor.~~

~~2. A respite agency must be used for all respite. The agency may be able to provide a staff person if a family is unable to locate a respite provider to be hired by the agency provider system, or due to medical problems that require a CNA or a nurse as respite provider.~~

~~3. The following steps should be taken to determine the appropriate level of respite services:~~

~~3.1 The family's request for respite and their proposed use for respite must be discussed prior to evaluating their level of eligibility according to the respite criteria.~~ ~~The family's eligibility under a specific level is not offered automatically.~~ ~~The Service Coordinator must evaluate the family's request, their need, natural supports, hours of program(s), travel time to and from program site(s), IHSS hours available to the family, etc. in determining the hours to be offered and document these findings.~~

~~3.2 The Service Coordinator should ask the caregiver what constitutes a "break" for him or her. Flexibility in how a family may choose to use respite hours should be assumed; however, respite may not be able to meet the family's total needs for recreation, household chores, and other family needs and activities. Therefore, families may need to use respite services for their highest priority relief activities. Parents are not required to leave their home during respite hours, and respite hours~~ ~~cannot~~ ~~be used to care for other children who are~~ ~~not~~ ~~developmentally disabled in the home.~~

~~3.3 The Service Coordinator should record the family's choice for use of respite services in the case records.~~

~~3.4 The family's eligibility level of service should be assessed. If the family exceeds the level of service for which they qualify, respite services will be limited by the level of service for which they do qualify.~~

~~3.5 Using the Respite Authorization Worksheet, the case record must reflect the criteria met by the family to justify their eligibility for the level of services being considered.~~

~~4. At the time of re-evaluation and determination of continued respite needs, the family's actual use of respite hours must be documented in the case record. The Respite Authorization Worksheet must reflect the criteria met by the family to justify their eligibility for the level of service being considered. When the level of service requires an Action Plan, this plan must be reviewed prior to reauthorization.~~ ~~The level of respite should be adjusted whenever possible as the family's needs change and as additional resources become available to the family the amount of hours may be reduced.~~

5. When Level E respite hours are requested and an Action Plan is required, it must be developed jointly with the family to address the individual specific situation which has necessitated the hours. Generic resources and natural supports should be utilized in lieu of respite as appropriate.

6. Families requiring Level E and above must be assessed for IHSS eligibility. Respite hours must consider the number of IHSS hours received and be modified accordingly. Respite hours should not duplicate IHSS services when the request for respite is covered by IHSS services. IHSS hours, and any other sources of respite services, e.g. public school, adult day centers and social recreational programs must be considered when discussing respite needs with the family. On a case by case basis the ID Team may reassess the level of service purchased by the regional center on the basis of the availability of IHSS hours designated for the same specific purpose. The IHSS Notice of Action Provided by the Department of Social Services must be provided for Planning Team review prior to authorization of respite services.
A copy of the IHSS Notice of Action must be provided on an annual basis. A consumer's school or day program attendance may be considered a form of respite for a non-working parent and may be considered as part of the total respite to be provided.

7. When discussing respite needs with the family, the respite policy criteria should be reviewed with the family and a copy made available upon request. The Respite Authorization Worksheet should be completed in consultation with the family.

8. The Respite Authorization Worksheet should be submitted with the POS request to the unit supervisor. It will be returned to the Service Coordinator and filed in the assessment section of the case record. For levels 0 and above the Respite Authorization Worksheet must be reviewed by the unit supervisor for approval prior to authorization.

9. If there is disagreement concerning the family's assessed need according to the stated criteria, the Service Coordinator will bring the issue to the unit supervisor for discussion. The unit supervisor may refer the request to the Planning Team for final determination. Upon final determination, the family has the right to appeal this Regional Center decision.

10. Respite needs are expected to change as the consumer's and family's needs change. Therefore, monitoring of the continued need for respite is essential. Purchase of Service authorizations may be written for a period of up to twelve (12) months, unless otherwise specified. Authorizations for respite services should not extend with an open-ended termination date. Review of authorizations are due annually based on the original date of the unit supervisor's approval, birth month or June 30th for new service starts if birth month has passed.

~~11. When assessing the consumer's needs related to medical or behavioral conditions, the Service Coordinator should document the consumer's caretaking needs over a 24 hour period in the case record. It is not sufficient to justify the level of service based on a general statement of need. The Planning Team shall review this information to substantiate the intensity of the consumer's needs.~~

~~12. If the caregiver has a health problem requiring respite services, a letter from the caregiver's physician is required and should address the medical condition, the limitations for the caregiver, and the length of time for recovery. This should be submitted with the Respite Authorization Worksheet for review by the unit supervisor and nurse consultant.~~

~~13. Authorized respite service hours should be used during each month as authorized. Hours may not accumulate to be used during a subsequent month.~~

~~14. The name(s) of the identified agency respite provider(s) must be included in the IPP/IFSP. If there is any possibility that the respite funds received are not being used for the authorized service, Service Coordinators will discuss this with the family. If the family cannot demonstrate reasonable appropriate use of the respite funds, the Service Coordinators will terminate the service provider with written 30 day notice to the family and offer a respite agency as an alternative provider.~~

~~15. When two or more siblings are regional center consumers and the family is authorized for respite services, a sibling rate is used for each consumer per agency funding policy. The family may or may not receive the same amount of respite services for each child. The assigned Service Coordinators must assess respite needs through a coordinated process.~~

~~16. When nursing respite is indicated and parents are adamant about non-agency provider respite, Service Coordinators are to obtain documentation from the consumer's primary care physician giving assurance to SCLARC that the consumer's condition is stable and their care may be provided safely by someone selected by the family. The person selected should be trained by a physician or medical staff in performance of specific medical procedures. This documentation must be in the case record prior to initiating respite services when the level of intervention is contradictory to SCLARC policy. (see nursing respite services below.)~~

B. NURSING SERVICES

Service Code: 854 - Home Health Agency

I. Definition

Nursing respite services are provided to those consumers who require a nursing level of respite due to their medical conditions. SCLARC will utilize nursing personnel through a nursing or home health agency for this service. A Registered Nurse (RN), Licensed Vocational Nurse (LVN) or Certified Home Health Aide (CHHA) will be used depending on the requirements of the consumer's medical condition and state licensing regulations as determined by SCLARC Nurse Specialists.

II. Criteria

Consumer conditions which require at least LVN level of care for respite services include, but are not limited to:

Gastrostomy
Tracheostomy care
Nasogastric feeding
Uncontrolled seizures, leading to respiratory or cardiac complications
Continuous oxygen
Total parental nutrition (TPN)
Apnea monitor
Apneas episodes
Fragile diabetes
Broviac catheter
Ventilator dependent
Invasive procedures required during respite hours (e.g. injections, suctioning, IV medications, and dialysis)
Prescribed medication required during respite hours Medically Fragile Complex Medical Regimens

A CHHA is used only when the consumer does not require skilled nursing care (see above examples) during respite hours. If the primary caregiver is remaining in the home and wishes to perform the skilled nursing care, a CHHA may be considered for respite services. A CHHA. may be indicated if the consumer's medical condition requires careful monitoring and supervision, but does not require skilled nursing care.

Most consumers requiring nursing respite may use LVN level of care. An RN may be indicated when the consumer has a Broviac catheter, TPN, or is ventilator-dependent.

The level of nursing personnel for nursing respite services must be determined by a SCLARC physician or nurse. The vendor agency supervisor may provide information regarding the appropriate level of nursing care according to licensing regulations, but shall not make the final decision.

Use of a licensed nurse to provide respite service is not to be confused with the need for in-home nursing services. In-home nursing services may be an on-going service need (refer to Procedures #3, In-Home Nursing Respite, for this service). Exceptions may be made on a case-by-case basis. All exceptions must be reviewed and approved by the SCLARC physician and/or nurse.

III. Procedures

1. Generic resources, e.g., private health care insurance, EPSDT, a Medi-Cal or a Community Based Waiver Program, may be available to provide the service. The Service Coordinator must pursue these resources and obtain denials when appropriate before considering SCLARC POS respite care services except in emergency situations requiring brief service authorization periods. Notes should reflect the generic resources explored, i.e., who was contacted and date of contact/denial. On a case by case basis, provision of services may be considered if there is an Action Plan to secure these resources. This requires approval by the unit supervisor and department director.

2. Nursing and Home Health Agencies hire nurses who work on a contract basis. Availability of nurses and supervisory skills vary between agencies and may change over time. Therefore, it is important to have current vendor resource information. A Service Coordinator, if unfamiliar with nursing resources, should consult SCLARC's Clinical Nurse Manager or the Chief of the Clinical Division.

3. On a case-by-case basis, based on the medical needs of the consumer, a private nursing vendor may be used. Private vendors do not receive supervision from other licensed personnel. A private vendor may be considered only when this service cannot be provided through a vendored agency. This must be recommended by SCLARC Nursing staff.

4. Nursing respite vendors (agencies and private vendors), due to the nature of their caretaking activities and the consumer's medical status which may change over time, must provide periodic documentation for the consumer's case file. This documentation should include the consumer's current Plan of Treatment (POT), Certification and Plan of Care, record of agency supervisory visits, and periodic nursing notes. The reporting requirements for a private nurse vendor should be more extensive than agency requirements due to the lack of nursing supervision. Service Coordinators should ensure that they are kept informed about the consumer's change in status. Service Coordinators must request updated information on a quarterly basis.

5. This respite service should be provided using the criteria for level of services and the procedures as described under the In-Home Respite Policy and Procedures.

6. Purchase of Service authorization and renewals for nursing respite services require the review and signature of the SCLARC physician or nurse on the POS rollover printouts.

7. Private nursing vendors shall not use a substitute in their place.

8. All nursing respite must be reviewed every six months.

*For families/consumers requesting in-home nursing respite through SCLARC's vendored in-home respite agencies please refer to Welfare and Institutions Code § 4686 of the Lanterman Act.

OUT-OF-HOME RESPITE SERVICES

Service Code: 868 - Out-of-Home Respite Services

I. Definition and Criteria

Out-of-home respite services means intermittent or regularly scheduled temporary care to individuals in a licensed facility. These services:

1. Are designed to relieve families of the constant responsibility of caring for a member of that family who is a consumer.

2. Meet planned or emergency needs.

3. Are used to allow parents or the individual the opportunity for vacations and other necessities or activities of family life.

4. Are provided to individuals away from their residence.

Out-of-home respite is not meant to be a preliminary to out-of-home placement and should not be used as a prelude to permanent placement.

Out-of-home respite services shall be available for families when the IPP specifies that it is a needed service. Families may receive **up to 21 days** of out-of-home respite in a fiscal year. This may not be combined consecutively with any days for the following fiscal year. There must be a period of at least 30 days between the out-of-home respite services used

in consecutive years. Out-of-home respite services may be spread out over the fiscal year, or the days may be used consecutively over the fiscal year.

When families use one week or more of consecutive out-of-home respite, regular in-home respite hours for the month shall be adjusted for that month. However, if the out-of-home respite services are spread out throughout the year, these hours will not affect the in-home respite hours.

II. Procedure

1. Service Coordinator will discuss the various natural supports and other existing community resources available to the consumer and his/her family. Families frequently have natural supports available to them, e.g. extended family, siblings, friends, neighbors, co-ops. To the extent that these resources would be available to assist the family of a non-disabled or high risk individual, they will be considered in the determination of respite needs. In-Home Supportive Services (IHSS), private insurance, Medi-Cal benefits, public school and other community resources must be pursued and utilized to the extent possible prior to SCLARC purchasing out-of-home respite services.

2. SC will identify possible residential facilities that will meet the respite needs of the consumer. SC will consult with the Placement Coordinator for vacancies in the identified residential facilities.

3. SC will consult with the Facility Liaisons and give the Facility Liaison a packet of information containing the recent IPP, annual review, CDER, face sheet, medical records, psych evaluation and other essential documents to successfully provide the needed respite service.

4. SC will obtain approval from the Facility Liaison, Administrator and the Placement Coordinator to place the consumer. SC will contact family and inform them of the secured out of home respite service. If the family and the consumer request to visit the facility, the address and Administrator's information will be given to them.

5. SC will submit and process the authorizations to secure the out-of-home respite service.

CAMP RESPITE SERVICES

Service Code: 850 - Camping Services
525 - Social Recreation Program (Residential Camp Day Camp)

I. Definition

Day camp or overnight camp provided during school vacations or during the summer period may provide an alternative creative and cost-effective resource for out-of-home respite services. Refer to the Policy and Procedure on Social/Recreational Services.

According to the needs of the consumer identified in the IPP, day camp may be considered as a respite service, day program or a socialization program. If day camp provides a respite service for the caretaker, then the authorized respite hours for that month will be adjusted based on the percentage of time spent in the day camp.

Overnight camp, if identified as a need in the consumer's IPP, will be considered an out-of-home respite service. When consumers attend overnight camp, regular in-home hours for the month will be adjusted, e.g., if one week of overnight camp is used, the regular respite authorization will be reduced for that month.

Policy

SCLARC can no longer purchase camp respite services due to changes in the law.

WIC §4648.5. (a) Notwithstanding any other provision of law or regulations to the contrary, effective July 1, 2009, a regional centers' authority to purchase the following services shall be suspended pending implementation of the Individual Choice Budget and certification by the Director of Developmental Services that the Individual Choice Budget has been implemented and will result in state budget savings sufficient to offset the costs of providing the following services:

(1) Camping services and associated travel expenses.

(2) Social recreation activities, except for those activities vendored as community-based day programs.

(3) Educational services for children three to seventeen, inclusive, years of age.

(4) Nonmedical therapies, including, but not limited to, specialized recreation, art, dance, and music.

(b) For regional center consumers receiving services described in subdivision (a) as part of their Individual Program Plan (IPP) or individualized family service plan (IFSP), the prohibition in subdivision (a) shall take effect on August 1, 2009.
(c) An exemption may be granted on an individual basis in extraordinary circumstances to permit purchase of a service identified in subdivision (a) when the regional center determines that the service is a primary or critical means of ameliorating the physical, cognitive, or psychosocial effects of the consumer's developmental disability, or the service is necessary to enable the consumer to remain in his or her home and no alternative service is available to meet the consumer's needs.

In the event that SCLARC considers an exception, the request must be submitted to the clinical interdisciplinary team for review, possible assessment and approval. (Refer to exception policy in section 2510 of the POS Standards)

RESPITE AUTHORIZATION WORKSHEET

CONSUMER:_____ UCI#:_____

SERVICE COORDINATOR:_____ DATE:_____

CORRESPONDING POS REQUEST AND REQUIRED SUPPORTING DOCUMENTS ATTACHED: _____
Supervisor Initials and Date

PLEASE INDICATE RELEVANT FACTORS IN ONE OR MORE AREAS
(Submit for POS Review)

Medical:
Behavioral:
Self-Care:
Caregiver Conditions:
Family Stress Factors:
Action Plan for Increased Respite Levels over 40 Hours and for Exceptions:

RESPITE AUTHORIZATION WORKSHEET

CONSUMER: **UCI#:** **S.C.:**

Number of Respite Hours/Month Approved: **Date:** **Supervisor's Initials:**

Three (3) or more checks in a given category may qualify for service at that level even with checks in lower levels. Services above 30 hours a month require I.D. Team Staffing along with supporting documents.

	LEVEL A: Up to 16 hrs./mo.	LEVEL B: Up to 24 hrs./mo	LEVEL C: Up to 30 hrs./mo.	LEVEL D: Up to 40 hrs./mo.	LEVEL E: Over 40 hrs./mo.
Medical	_Special medical needs	_Intermittent physical or medical needs (e.g., special care on weekly basis)	_Medically fragile; requires care on periodic basis during day (G-tube feedings, etc.) Stable condition. Nursing assessment required	_Medically fragile; requires care on periodic basis during day (G-tube feedings, etc.) Unstable condition. Nursing assessment required	_Medically fragile; requires care on an hourly basis; at risk for choking and aspiration at any time. Nursing assessment required.
Behavior	_Behavior difficult to manage	_Demonstrating intermittent challenging behaviors beyond age-expectation (aggression, self-abuse, etc.)	_Demonstrating ongoing challenging behaviors beyond age-expectation (aggression, self-abuse, etc.). Behavioral Assessment required	_Exhibiting severe behavioral concerns, injuring self/others __Requires continuous supervision due to disruptive/destructive behavior (e.g., biting, smearing feces, periodic AWOL)	Behavioral assessment required
Self-Care	__Requires supervision related to disability	__Requires prompting or assistance in two or more areas	_Consumer has physical or medical condition requiring frequent treatment	Consumers over 18 years old and requires total care in areas of personal hygiene, bathing, feeding, etc.	_Non-ambulatory; requires hands-on assistance to complete self-care/ independent living tasks; weighs over 80 lbs.
Caregiver Condition	_Stress related to consumer's disability	__Single parent _Adolescent parent __D.D. parent __Caregiver has physical or medical condition causing difficulty in caring for consumer	_Caregiver has physical or medical condition requiring frequent treatment.	_Caregiver chronic physical or medical issues impacting consumer's care __Caregiver also cares for another family member with chronic illness __Caregiver with no assistance experiences sleep disruption nightly (up to 2 hrs./night)	__Caregiver with life-threatening medical condition which interferes with consumer's care (e.g., cancer, etc.) __Caregiver with no assistance experiences sleep disruption nightly (e.g., treatments every 2 hrs.; feedings over 1 hr.)
Family Stress	__Natural supports do not meet respite needs __Unable to find services due to disability	_Family disruption due to consumer's disability _Caregiver attends regular support groups	__2 or more South Central Los Angeles Regional Center consumers in family __At risk of being abused _Family receiving counseling for stress issues	_2 or more consumers in family; 1 with challenging behavior or medical needs _Single parent; consumer with Level C behavior or medical needs and no other supports	_Severity and/or combination of Level D criteria necessitates additional hours

FUNDING STANDARDS
Social Recreational Service

SOCIAL RECREATIONAL SERVICES

Service Code: 525 - Social Recreation Program (non-community based)

I. Definition

Social/recreational services are designated to enhance the social interaction opportunity and skill, which enable the consumer to participate in group and individual activities at home and in the community. Such services encourage consumers to initiate communication with others, teaches appropriate social skills, and appropriate leisure time skills. A socialization/social/recreational service is considered a temporary service intended to promote transition into an integrated generic social setting. It is not a permanent day program.

Policy

SCLARC can no longer purchase social recreation activities due to the changes in the law.

WIC §4648.5. (a) Notwithstanding any other provision of law or regulations to the contrary, effective July 1, 2009, a regional centers' authority to purchase the following services shall be suspended pending implementation of the Individual Choice Budget and certification by the Director of Developmental Services that the Individual Choice Budget has been implemented and will result in state budget savings sufficient to offset the costs of providing the following services:
(1) Camping services and associated travel expenses.
(2) Social recreation activities, except for those activities vendored as community-based day programs.
(3) Educational services for children three to seventeen, inclusive, years of age.
(4) Nonmedical therapies, including, but not limited to, specialized recreation, art, dance, and music.
(b) For regional center consumers receiving services described in subdivision (a) as part of their Individual Program Plan (IPP) or individualized family service plan (IFSP), the prohibition in subdivision (a) shall take effect on August 1, 2009.

(c) An exemption may be granted on an individual basis in extraordinary circumstances to permit purchase of a service identified in subdivision (a) when the regional center determines that the service is a primary or critical means of ameliorating the physical, cognitive, or psychosocial effects of the consumer's developmental disability, or the service is necessary to enable the consumer to remain in his or her home and no alternative service is available to meet the consumer's needs.

In the event that SCLARC may consider an exception, the request must be submitted to the clinical interdisciplinary team for review, possible assessment and approval. (Refer to exception policy in section 2510 of the POS Standards)

Funding Standards
Equestrian Recreation Therapy

EQUESTRIAN RECREATION THERAPY

Service Code: 106 - Specialized Recreational Therapy

I. Definition

Equestrian Recreation Therapy provides a social/recreational experience for both adult and minor consumers via horseback riding. Equestrian programs that do not employ occupational therapists or physical therapists, or have OT or PT available cannot be considered to provide therapy to address motor or other physical disabilities. Equestrian programs therefore, are generally considered to address motor functioning. In some cases, equestrian training can enhance a consumer's fine and gross motor functioning by training the consumer to position his or her body on the horse and handle the horse for the purpose of riding. Equestrian Recreation Therapy is sometimes used to enhance a consumer's self-esteem by facilitating their ability to engage in and be successful in a new and enjoyable activity. For those individuals residing in community care facilities, social recreation activities are the responsibility of the residential care provider. Equestrian Therapy providers must also possess a current program accreditation and instructor certification with the North American Riding for the Handicapped Association (NARHA).

Policy

SCLARC can no longer purchase equestrian recreation therapy due to the changes in the law.

WIC §4648.5(a) Notwithstanding any other provision of law or regulations to the contrary, effective July 1, 2009, a regional centers' authority to purchase the following services shall be suspended pending implementation of the Individual Choice Budget and certification by the Director of Developmental Services that the Individual Choice Budget has been implemented and will result in state budget savings sufficient to offset the costs of providing the following services:

(1) Camping services and associated travel expenses.
(2) Social recreation activities, except for those activities vendored as community-based day programs.
(3) Educational services for children three to 17, inclusive, years of age.

(4) Nonmedical therapies, including, but not limited to, specialized recreation, art, dance, and music.

(b) For regional center consumers receiving services described in subdivision (a) as part of their Individual Program Plan (IPP) or individualized family service plan (IFSP), the prohibition in subdivision (a) shall take effect on August 1, 2009.

(c) An exemption may be granted on an individual basis in extraordinary circumstances to permit purchase of a service identified in subdivision (a) when the regional center determines that the service is a primary or critical means of ameliorating the physical, cognitive, or psychosocial effects of the consumer's developmental disability, or the service is necessary to enable the consumer to remain in his or her home and no alternative service is available to meet the consumer's needs.

In the event that SCLARC may consider an exception, the request must be submitted to the clinical interdisciplinary team for review, possible assessment and approval. (Refer to exception policy in section 2510 of the POS Standards)

FUNDING STANDARDS
Specialized Supervision

SPECIALIZED SUPERVISION
(A.K.A.: Extended Day/Extended Year/After School and Saturday Programs)

Service Code: 525 - Social Recreation Program
850 - Camping Services (Saturday Program)
851 - Child Day Care

I. Definition

Specialized supervision services are provided to school age persons during after-school hours (1) when their health and safety would be jeopardized without supervision; (2) when there is no generic resource available; (3) when parents are unable to provide supervision due to both parents working in dual parent households or 1 parent in single family households and; (4) when no supervision would be required if the consumer were not disabled. For those individuals residing in community care facilities, specialized supervision is the responsibility of the residential care provider. These services are not designed to be used as child care and are purchased only when they are necessary to maintain the consumer in the natural family home. Children not attending school are ineligible for this service.

Policy

SCLARC **can no longer purchase camping services and associated travel expenses; social recreation activities, except for those activities vendored as community-based day programs;** educational services for children ages three to 17; and non-medical therapies, including, but not limited to, specialized recreation, art, dance, and music pending implementation and certification of the Individual Choice Budget. SCLARC may grant an exemption on an individual basis in extraordinary circumstances to permit the purchase of a service identified above when the regional center determines that the service is a primary or critical means for ameliorating the physical, cognitive, or psychosocial effects of the consumer's developmental disability, or the service is necessary to enable the consumer to remain in his or her home and no alternative service is available to meet the consumer's need.

WIC §4648.5(a) Notwithstanding any other provision of law or regulations to the contrary, effective July 1, 2009, a regional centers' authority to purchase the following services shall be suspended pending implementation of the Individual Choice Budget and certification by the Director of Developmental Services that the Individual Choice Budget has

been implemented and will result in state budget savings sufficient to offset the costs of providing the following services:

(1) Camping services and associated travel expenses.
(2) Social recreation activities, except for those activities vendored as community-based day programs.
(3) Educational services for children three to 17, inclusive, years of age.
(4) Nonmedical therapies, including, but not limited to, specialized recreation, art, dance, and music.
(b) For regional center consumers receiving services described in subdivision (a) as part of their Individual Program Plan (IPP) or individualized family service plan (IFSP), the prohibition in subdivision (a) shall take effect on August 1, 2009.
(c) An exemption may be granted on an individual basis in extraordinary circumstances to permit purchase of a service identified in subdivision (a) when the regional center determines that the service is a primary or critical means of ameliorating the physical, cognitive, or psychosocial effects of the consumer's developmental disability, or the service is necessary to enable the consumer to remain in his or her home and no alternative service is available to meet the consumer's needs.

In the event that SCLARC may consider an exception, the request must be submitted to the clinical interdisciplinary team for review, possible assessment and approval. (Refer to exception policy in section 2510 of the POS Standards)

FUNDING STANDARDS
Preschool and Other Child Day Care

PRESCHOOL AND OTHER CHILD DAY CARE

Service Code: 851 - Child Day Care/Preschool

I. Definition

Day care services is regularly provided care and supervision for periods less than 24 hours a day while parents are engaged in employment outside of the home or educational activities leading to employment or both. There are three basic types of child day care providers. The three types are as follows:

1) Non-medical care and supervision, provided by a vendor with a valid family day care license, to children under age 18 years old on a less than 24-hour per day basis in the vendor's own home;
2) Personal care, protection, supervision and assistance, provided by a vendor with a valid day care license, to children under 18 years old with special developmental needs in a nonresidential facility;
3) Aid to children in developing pre-academic skills, group training, and social skills, provided by a vendor with a valid preschool license or a child care center license, in a non-residential facility.

When considering whether a child will receive Child Day Care Service and/or other services as part of his or her IFSP/IPP, the Interdisciplinary Team must consider, among other things, the fact that children with developmental disabilities most often have greater opportunities for educational and social growth when they live with their families. Thus, a high priority is placed on providing opportunities to allow children with developmental disabilities to remain in the family home, when living at home is a preferred objective in the child's individual program plan. In determining which supports and services are necessary to assist a child and his or her family in attaining the IFSP/IPP goals, the Regional Center will respect and support the decision making authority of the family and be flexible and creative in meeting the family's unique and individual needs as they evolve over time. At the same time, the IPP should recognize and build on family strengths, natural supports and existing community supports and be designed to meet the cultural preferences, value and lifestyles of families. The IPP should focus on the entire family and promote inclusion of consumers in all aspects of school and the community. Services should be effective in meeting the goals stated in the IPP,

reflect the preferences and choices of the child's family and reflect the cost-effective use of public resources.

The Lanterman Act provides that Regional Centers may purchase or provide vouchers for day care services for parents caring for children in the home, but *only* to the extent that the cost exceeds the cost of providing day care services to a child without disabilities. The Regional Center may pay in excess of this amount when a family can demonstrate a financial need and when doing so will enable to the child to remain in the family home. (WIC § 4685 (c)(6)).

Eligible infants and toddlers up to age 3 years receive services from the Regional Center under the Early Intervention Services Act (commonly referred to as "Early Start"). These comprehensive services are often provided at a specialized center-based early intervention/preschool program, pursuant to an Individualized Family Service Plan (IFSP). Parents are expected to attend pre-school programs with their children. Generally, these educational and therapeutic services are funded by generic resources, not by the Regional Center. The Regional Center funds for supplemental or additional services depending on the needs of the child and family, which are determined by the program planning process.

At or prior to the child attaining three years of age, a determination is made as to whether the consumer has a developmental disability and thus eligible to receive Regional Center services pursuant to the Lanterman Developmental Disabilities Services Act ("the Lanterman Act"). If the child has a developmental disability, he or she may remain in the pre-school setting where he or she was receiving Early Start services or transfer to another pre-school setting.

Most children 3 to 5 years of age are considered to be preschoolers. Many Regional Center consumers of this age receive educational and other services funded by their local education agency as required by the federal law known as the "Individuals with Disabilities Education Act." Transportation is provided to and from a site providing special education services.

Preschool services for children with disabilities are usually free of charge to the family or require payment on a sliding scale, if not funded by the local education agency and provided pursuant to an Individualized Education Plan, i.e. a plan for special education services. The Regional Center may fund for pre-school services after exploring all generic sources for funding. School-aged Regional Center consumers (5 years old to 21 years old) often require specialized supervision for safety reasons. Child Day Care services for

children of this age are designed to provide only basic care and supervision. Such services may be funded if parents work full-time or attend school full-time. Natural supports, generic services, and other cost-effective programs must be explored prior to funding for Child Day Care Services. Based on the principle cited above from the Lanterman Act, normal parental responsibilities will be considered when determining whether the Regional Center will fund for such supervision. After-school programs and inclusion programs may be the most cost-effective manner of providing supervision to school-aged consumers and such programs shall be explored prior to providing funding for Child Day Care. The Regional Center encourages families to seek natural supports as well as cost-effective inclusion programs. The Regional Center may provide temporary supportive services, which will allow the child to attend an inclusion program. This might be in the form of training to the program staff or support to the child. Extended School Year Services are provided in accordance with the individual needs of persons attending school whose parents are unavailable to provide supervision because of their employment during customary school hours. When an individual's need exceeds usual and customary, SCLARC will pay the cost which is considered over and above parental responsibility. However, holidays and "pupil free" days are considered parental responsibility

The portion of which the Regional Center may fund for any of the services that provide supervision to a minor consumer will be based on, among other considerations, the child's age and severity of disability. Generally, all children age 5 years to 12 years old require a level of adult supervision. Typically developing children, 13 years old and older, do not require constant adult supervision during after-school hours. On the other hand, parents of typically developing children of this age often pay for summer or other programs. These and other factors will be considered when determining parental responsibility for providing supervision for consumers. The cost of supervision over and above what a family would pay for a non-disabled child of a certain age may be funded by the Regional Center if all criteria set forth in sections two and three are met.

In 2004, the California State Legislature created a program that mandates that some families will have to pay for a portion of respite, child care and camping services. This law is called the Family Cost Participation Program (FCPP). This law applies to families who meet the following criteria:

- The child has a developmental disability
- The child is zero (0) through seventeen (17) years of age
- The child lives in the parents' home
- The child is not eligible for Medi-Cal

The Family Cost Participation Program was created under the provisions of the Welfare and Institutions Code Section 4783 (a) (1).

Regional Market Rate Ceilings will be utilized to assist the Interdisciplinary Team in determining the monetary responsibility of parents. Reimbursement to the child care providers shall be based on the lesser of the regional market rate ceiling, the established rate or the derived rate. If an established rate is unavailable, reimbursement shall be based on the lesser of the regional market rate ceiling, the comparable local rate or the provider's requested rate. Because the Regional Center's consumer may require more care and supervision than that of a typically developing minor, the Regional Center will fund the service at a rate that is in accordance with the California Administrative Code title 5,s 18075.2. This code sites, "*(a) When child care and development services are provided to a child with exceptional needs, the contractor shall multiply the lesser of the regional market rate ceiling or the rate determined pursuant to Section 18074.3 or 18074.4 which ever is lower, by the one of the following: (1) by 1.2, when the child has exceptional needs or (2) by 1.5, when the child is severely disabled…."*

Children with "exceptional needs" means either of the following:

(1) Infants and toddlers under three years of age who have been determined to be eligible for early intervention services pursuant to the California Early Intervention Services Act (Title 14 (commencing with Section 95000) of the Government Code) and its implementing regulations. These children include an infant or toddler with a developmental delay or established risk condition, or who is at high risk of having a substantial developmental disability, as defined in subdivision (a) of Section 95014 of the Government Code. These children shall have active individualized family service plans, shall be receiving early intervention services, and shall be children who require the special attention of adults in a child care setting.

(2) Children ages 3 to 22 years, inclusive, who have been determined to be eligible for special education and related services by an individualized education program team according to the special education requirements contained in Part 30 (commencing with Section 56000), and who meet eligibility criteria described in Section 56026 and Sections 56333 to 56338, inclusive, and Sections 3030 and 3031 of Title 5 of the California Code of Regulations. These children shall have an active individualized education program, shall be receiving early intervention services or appropriate special education and related services, and shall be children who require the special attention of adults in a child care setting. These children include children with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance (also referred to as emotional

disturbance), orthopedic impairments, Autism, traumatic brain injury, other health impairments, or specific learning disabilities, who need special education and related services consistent with paragraph (A) of subsection (3) of Section 1401 of Title 20 of the United States Code.

"Severely disabled children" are children with exceptional needs from birth to 21 years of age, inclusive, who require intensive instruction and training in programs serving pupils with the following profound disabilities: Autism, blindness, deafness, severe orthopedic impairments, serious emotional disturbances, or severe mental retardation. "Severely disabled children" also include those individuals who would have been eligible for enrollment in a developmental center for handicapped pupils under Chapter 6 (commencing with Section 56800) of Part 30 as it read on January 1, 1980.

The “Regional Market Rate” is defined as the current rate charged for the various types of child care services as determined by a survey of providers and adopted by the California Department of Education.

II. Criteria for Regional Center Funding for Pre-school Programs

The Regional Center will fund for pre-school services for consumers only when their disability or condition related thereto prevents acceptance into a Head Start program or other generically funded pre-school program. This may be due to one of the following:

1. The consumer has more than one (1) handicapping condition.
2. The consumer is not toilet trained.
3. The consumer is not ambulatory.
4. The consumer is Deaf or Blind.
5. The consumer requires special equipment such as a wheelchair.
6. The consumer requires constant supervision because of behaviors/problems resulting from the disability.
7. The consumer’s functioning is lower than mild mental retardation.

Note: Purchase of service for centers such as Dominguez Hills Infant Toddler Program should only be considered for children from eighteen months to three (3) years of age.

III. Criteria For Regional Center Funding For Child Day Care Day Care Services For Children 5 Years Of Age To 22 Years of Age

All of the following must be met:

1. The consumer’s health and/or safety will be in jeopardy without supervision because of the nature of his or her disability.

2. All alternative natural resources for supervision have been ruled out.

3. All generic resources for funding supervision for the consumer have been ruled out.

4. The consumer has a single parent who is working full-time or in a full time education or vocational program *or* the consumer has two parents and both work full-time or attend a full-time education or vocational program.

5. The consumer requires constant supervision or total support due to physical and/or medical challenges, *or* the consumer has severe behavior challenges constituting a threat to the consumer, others or property (in such cases, an assessment will be required to determine what other effective measures should be taken to alleviate the behavioral challenges), *or* the Interdisciplinary Team determines that other circumstances exists which justify Regional Center funding.

6. Cost-effective inclusion programs have been explored and ruled out prior to funding a segregated Child Day Care program for disabled children;

6. For children age 5 years to 13 years old, the Regional Center shall consider the parent's responsibility for funding Child Day Care or other after-school or summer programs that provide supervision for a child without a disability and shall fund only for that portion that exceeds such typical costs;

   a) For children 13 years of age or older, the Regional Center shall consider the parent's responsibility for funding summer programs that provide supervision for a child of this age without a disability. Funding for Child Day Care shall be provided only to the extent that it exceeds a parent's responsibility for funding supervision for children of this age range without a disability.

Information and Procedures

A. Preschool:

1. Most Head Start Centers operate from September through June and referrals are taken during these months. A directory is available through the Education Specialist.

2. A one-year authorization is generally acceptable for Regional Center funded programs.

3. Referrals to all preschool programs should be made to SCLARC's Education Specialist.

4. General application and other requirements for pre-school programs.

    a. Current Immunization records.

    b. Birth Certificate

    c. TB Test or chest X-ray

    d. Verification of income

    e. Parent participation

    f. Proof of residence in the pre-schools catchment area.

    g. The child's intellectual functioning level is characterized as mild retardation or above or whose physical disability is considered to be mild (i.e., CP, seizure disorder).

B. Public School Facilities:

1. Parent/guardian must contact home school and request in writing a special education placement.

2. Within 30 days an IEP should be scheduled and placement recommendations concluded.

3. No purchase of service authorization is required for public school services.

4. SC and/or Education Specialist should make every effort to attend IEP meetings along with SCLARC consumer's representatives (parent or guardian). They should assist family in advocating for all needed services, including any appropriate after-school programs or extended year services.

SERVICES AVAILABLE FREE OF CHARGE:

There are generic services free of charge available for children living in South Central Los Angeles, Compton, Willowbrook and nearby areas. There are also generic CHILD CARE SUBSIDY PROGRAMS designed to help pay for childcare needs for those income eligible families who are either working, in school, in training, or seeking work. The funds may be used to pay for home-based childcare sites, licensed pre-school facilities, or SCLARC vendored programs.

FUNDING STANDARDS
Preschool and other Child Day Care

PRESCHOOL FACILITIES/EARLY START

Service Code: 851 – Child Day Care

1. Definition

Natural Environment: Federal mandate requires that *"high-risk"* and DD children between the ages of 0-3 receive services in the same setting as a typical child of the same age (as appropriate). A *"natural environment"* includes *"in-home",* as well as Early Head Start Programs and Day Care/Preschool facilities.

******General eligibility requirements:

1. Current immunization records
2. Proof of birth
3. Medical
4. Must reside in the catchment area

II. Criteria

All children should be considered for funded Day Care/preschool programs (even if part-time) unless the child exhibits such behavior or high-risk conditions in which their needs cannot be met is such setting.

III. Procedure

A. Preschool/Day Care:

1. Most Day Care facilities operate throughout the year.
2. Funding will be at the usual and customary fee only.
3. Referrals to all Day Care should be made to the Early Start Manager or designee(s)

SERVICES AVAILABLE FREE OF CHARGE;

Early Head Start Centers

These centers are available free of charge to children 0-3 years of age. The program is offered on a half-day – full-day schedule depending on the child/family needs.

These centers are established for low-income families, but will accept any child age 0-3 provided that their needs can be met in this environment.

***may vary depending on the Day Care Facility**

FUNDING STANDARDS
Adult Day Programs

ADULT DAY PROGRAMS

Service Code: 510 - Adult Development Center
515 - Behavior Management Program
505 - Activity Center

I. Definition and Criteria

Adult day programs are structured community based services that develop, enhance or maintain a variety of skills that enable adults to maximize their independent functioning. Depending upon the needs of the individual and service focus, program objectives can range from maintenance of self-help skills to job training and supported employment.

Service Code 505 - "Activity Center" denotes a community-based day program that serves adults who generally have acquired most basic self-care skills, have some ability to interact with others, are able to make their needs known, and respond to instructions. Activity center programs focus on the development and maintenance of the functional skills required for self-advocacy, community integration and employment.

Activity Centers offer a senior program component for consumers over 50 years of age. The service is designed for eligible consumers who want to transition to a program specifically designed for seniors. At the time of the development, review or modification of the consumer's IPP, information about this alternative service will be provided.

Activity Centers also offer an alternative customized program component with staffing ratios appropriate to meet individualized consumer needs. The "Customized Endeavors Option" is offered to eligible consumers who want to focus on their individualized needs and interests to develop or maintain employment or volunteer activities in lieu of their current program. Service hours are limited between 20 and 80 hours per month for each participant. At the time of the development, review or modification of the consumer's IPP, information about this alternative service will be provided.

Service Code 510 - "Adult Development Center" denotes a community based day program for adults who are in the process of acquiring self-help skills. Individuals who attend adult development centers generally need sustained support and direction in developing the ability to interact with others, to make their needs known, and to respond to instructions. Adult

development center programs focus on the development and maintenance of the functional skills required for self-advocacy, community integration, employment, and self-care.

Adult Development Centers offer a senior program component for consumers over 50 years of age. The service is designed for eligible consumers who want to transition to a program specifically designed for seniors. At the time of the development, review or modification of the consumer's IPP, information about this alternative service will be provided.

Adult Development Centers also offer an alternative customized program component with staffing ratios appropriate to meet individualized consumer needs. The "Customized Endeavors Option" is offered to eligible consumers who want to focus on their individualized needs and interests to develop or maintain employment or volunteer activities in lieu of their current program. Service hours are limited between 20 and 80 hours per month for each participant. At the time of the development, review or modification of the consumer's IPP, information about this alternative service will be provided.

Service Code 515 - "Behavior Management Program" denotes a community--based day program that serves adults with severe behavior disorders and/or dual diagnosis who, because of their behavior problems, are not eligible for or acceptable in any other community-based day program. These programs are required to develop behavioral treatment plans and to provide SCLARC with quarterly progress reports.

Behavior Management Programs offer a senior program component for consumers over 50 years of age. The service is designed for eligible consumers who want to transition to a program specifically designed for seniors. At the time of the development, review or modification of the consumer's IPP, information about this alternative service will be provided.

Behavior Management Programs also offer an alternative customized program component with staffing ratios appropriate to meet individualized consumer needs. The "Customized Endeavors Option" is offered to eligible consumers who want to focus on their individualized needs and interests to develop or maintain employment or volunteer activities in lieu of their current program. Service hours are limited between 20 and 80 hours per month for each participant. At the time of the development, review or modification of the consumer's IPP, information about this alternative service will be provided.

Service Code 702 – "Adult Day Health Center" programs may be purchased for adult consumers for the purpose of maximizing

opportunities for community integration, interaction with non-handicapped peers and productive work. Up to five days per week of adult day programming may be purchased depending upon consumer assessment and need as well as the consumer's and legal representative's choice. Service Coordinators, in addressing the day programming needs of adult consumers should consider the program's proximity to the residence of the consumer as a priority whenever there is a choice of programs as well as access to or availability of reasonable transportation to and from the program of choice. In those instances where the primary focus is maintenance of skills, fewer hours or days of service may be needed to achieve objectives as cited on the consumer's IPP. Support services for working adults should gradually decrease to the minimum needed for stabilization of employment.

II. Procedure

The Service Coordinator shall obtain a review with recommendations for selecting an appropriate adult day program. Behavioral Management Day Programs require behavior specialist review and approval upon entry and must include a timeframe or designated phasing out period (criteria for transition to another setting) as part of the total plan.

III. Alternatives To Purchase of Adult Day Programs

The availability and appropriateness of generic adult day programs should be explored by the Planning Team. The Planning Team should consider the use of community colleges, public education programs for consumers under the age of 22 and programs funded by the Department of Rehabilitation (Vocational Habilitation or supported employment services) whenever these programs are available and appropriate to the needs of the consumer. Los Angeles Unified School District runs twenty-six (26) Exceptional Adult School Programs that are associated with regular high school campuses. The Adult School system is an enriching program that has a variety of curricula at various locations throughout the district. Private facilities such as Exceptional Children's Foundation, United Cerebral Palsy, etc. also have Adult School programs on site. The programs teach basic life skills and practical skills development, including body dynamics for physically impaired, lip reading, finger spelling, etc. A teacher from the school district is provided for these classes.

Los Angeles Unified School District also operates Regional Occupational Training Centers. Students that are Hearing Impaired, Physically Handicapped and Learning Handicapped may enroll in approximately 100 different occupational courses at five Regional Occupational Centers.

Related services are generally not provided in the Adult Education classes (i.e., speech, therapy, transportation and counseling).

Adult education catalogues are available through the Adult Education offices of individual school districts. This service is free of charge for eligible adults 18 years and over. Additionally, adult programs such as Exceptional Adult Center are located in our catchment area and constitute five days a week, eight hours a day programs.

FUNDING STANDARDS
Independent Living

INDEPENDENT LIVING TRAINING PROGRAMS

Service Code: 520 - Independent Living Program

Independent Living Skills (ILS) training is defined as a program that provides adults functional skills training necessary to secure a self-sustaining, independent living situation in the community and/or provide the support necessary to maintain those skills.

For individuals who do not have legal and financial control over their residence, the teaching of ILS may be addressed as part of the primary day program or through generic resources such as the Department of Rehabilitation (DOR) or in the home. This includes individuals who reside with their own family or those who reside in a CCF and choose independent living services when transitioning and returning to their home. The individual must be at least 18 years of age.

Persons may receive up to 15 hours per month of ILS for the first 6 months. The need for additional time will be reassessed at that time. Some individuals may require additional training in independent living skills to enable them to move to, or maintain a more independent living arrangement. In those circumstances the volume of service will be determined by the Interdisciplinary Team

I. Definition

Training in independent living consists of programs that assist individuals to develop skills that will enable them to live independently or semi-independently. These programs begin with an individual assessment, provide specific training in deficit areas, and provide time-limited transition and monitoring services.

Such programs shall provide instruction which includes, but is not limited to: cooking, cleaning, shopping, menu planning, meal preparation, money management, use of public transportation, task completion, homemaking skills, self-reliant behaviors, sex education, family and parenting skills as well as community resource awareness (e.g., police, fire, or emergency help).

Training may be provided in the consumer's own home, in an apartment living/training situation, or in a community program which is not licensed

as a 24 hour community care facility. Independent living skills training programs will be authorized by SCLARC for only 60 days and will be reviewed for clinical appropriateness and consumer progress towards greater independence before being authorized. Independent living should not be purchased for individuals under the age of 18. Daily living activities (grooming, bathing, teeth brushing, toileting, etc.) are self-help skills and shall not be included in independent living programs. A consumer is expected to have acquired these skills before being considered for an independent living program.

II. Criteria

SCLARC may purchase training if the consumer is age 18 or over and it is determined that he or she meets all of the following criteria:

A. Has appropriate skills before entering a program to complete training in approximately 24 months as indicated by an independent living training skills assessment;

B. Demonstrates an understanding of the goals and expectations of the program through informal interviewing and testing, and expresses a willingness to participate in and complete the program;

C. Has no medical, behavioral or other problems which would prevent one from developing independent living skills. Those consumers with physical limitations (i.e., due to CP) may need an OT or PT assessment of functional status; need for adaptive equipment and environmental adaptations, wheelchair mobility and transfers, etc.;

D. Has ability to maintain self in the community with appropriate supports, without jeopardizing health and safety.

E. Does not have any problem that requires continuous monitoring which would preclude consumer placement in an unsupervised setting;

F. Is not in public school system or part of another generic resource.

III. Referral to a Training Program

A. Once a provider has been determined, an authorization for the purchase of service is completed for a 60 day assessment period. After the 60 days, a meeting is held with the provider, consumer, family (when appropriate) and relevant SCLARC staff to determine

if the consumer is making sufficient progress in the program to justify ongoing funding.

The number of hours authorized will be determined by the specific independent living skills required by the consumer to be self-sustaining, as reflected on the IPP and by the time required to teach the specific skills. Skills training purchased by SCLARC will be time-limited (not to exceed two years at 30 hours per month maximum per consumer) and shall focus on specific objectives related to independent living.

B. The consumer's IPP should identify and document specific areas of skill deficit and progress.

Quarterly face-to-face contact with the consumer is required of the SC. Continuation of funding beyond the initial authorization must be based on documented progress and realistic expectation of achievement of time-limited objectives. Continued funding for independent living skills training shall be based on the clinical appropriateness of the training considering the objectives in the previous year. The review and any recommendations for continuation of funding shall consider alternatives for helping the consumer achieve greater independence in living.

C. Those consumers who have successfully completed an independent living skills program may continue to receive independent living follow-up when it is needed to maintain the consumer's independent or semi-independent living arrangement in the community.

Basic rent may be provided for a consumer in an "independent living" training program if SSI is denied and the denial is under appeal, or, there is no other resource.

FUNDING STANDARDS
Independent Living
Support Services

INDEPENDENT LIVING SUPPORT SERVICES

Service Code: 520 – Independent Living Program

Consumers who are living independently are encouraged to maintain supportive contacts with family members, community organizations, friends and others who can offer them occasional assistance and advice. Independent Living Support services are designed to complement, not replace those support systems.

For consumers who continue to need a limited amount of one-to-one supervision or training each month to maintain independence beyond that offered through other sources, the Regional Center can purchase Independent Living Support Services.

I. Definition

Independent living support is intended for consumers who have successfully completed an independent living skills training program or where the service is needed to maintain independent, semi-independent living arrangements. This service provides support/reminders/ encouragement/monitoring for individuals to perform at their fullest potential for independent living. This service is part of a continuum of independent living skills services and reinforces independent living skills training.

II. Criteria

A. Consumer has successfully completed Independent Living Skills training or is living independently but continues to need a limited amount of supervision and/or training.

III. Referral for Support Services

A. The amount of support services shall be determined by a clinical decision based upon individual consumer needs. These needs must relate to success in living in a minimally restrictive environment. Progress must be documented. The goal is to reduce the amount of support necessary to maintain a successful independent living arrangement.

FUNDING STANDARDS
Independent Living

B. Consumers requiring more than 15 hours per month of service will be reviewed to determine the appropriateness of their independent living arrangement by the Planning Team and the POS Committee.

Each authorization shall be reviewed at least every six months. Renewal shall be made only if satisfactory progress has been documented during the period the support services were provided. The review and any recommendations for continuation of funding shall consider alternatives for helping the consumer achieve greater independence in living.

C. Consumers who successfully completed an independent living skills program may continue to receive independent living follow-up when it is needed to maintain the consumer's independent or semi-independent living arrangements in the community.

SUPPORTED LIVING SERVICES

Service Code: 896 - Supported Living Services

Supported Living Services (SLS) are those services provided by agencies or individuals that support adults' efforts to live in their own homes, participate in activities to the extent of their interests and capacities, and realize their maximum potential. Individuals reside in settings that are typical of those in which persons without disabilities reside. Support services, which may change, are provided based on individual needs for as long as needed. In supported living arrangements, the regional center funded services complement generic and natural supports such as In Home Support Services (IHSS), subsidized housing, and the involvement of family and friends. In cases where regional center funding is needed prior to the start of IHSS, the rate shall be at the established IHSS rate for the county of residence. Supported Living Services shall not be purchased to supplant IHSS or in cases when an otherwise qualified individual refuses to apply for IHSS.

The IDT shall confirm that all appropriate and available sources of natural and generic supports have been utilized to the fullest extent possible. The same supported living provider shall be used for all individuals residing in the same home provided that each individual's particular needs can still be met pursuant to his/her IPP.

Rent, mortgage, lease payments and household expenses shall be the responsibility of the individual and any roommate who resides with that person.

A supported living services provider shall provide assistance to an individual who is a Medi-Cal beneficiary in applying for In-Home Supportive Services within 5 days of the person moving into a supported living services arrangement. Referral to supported living agencies is determined through the IPP process.

Eligibility for SLS

An individual shall be eligible for SLS upon determination made through the IPP process that the individual:

(a) is at least age 18 year of age (planning may begin prior to age 18);

(b) has expressed directly or through the individual's personal advocate a preference for SLS among the options proposed during the IPP process

(c) is living in a home that is not the place of residence of a parent or conservator of the individual.

Individuals shall not be denied eligibility for SLS solely because of the nature and severity of their disabilities.

The IDT must review the SLS assessment and the support plan to assure that:

(a) the recommendations are appropriate to meet the goals of the IPP

(b) all regulatory requirements that pertain to supported living arrangements must be met.

I. Definition

Adults with Developmental Disabilities, regardless of the degree of the disability, have the right to live in homes of their own choice, as long as they want and with whom they want, and to be provided with services that will ensure and enhance their success with integration into the mainstream of society. Supported Living Services (SLS) is a shift in thinking for programs and funding agencies from valuing time limited, measurable, instructional and behavioral goals to valuing choices, needs and satisfaction of people with disabilities.

It is the goal of the Supported Living Services program to provide services according to consumer preference and interest and to assist with generic services and supports in the consumer's natural community, in the most cost-effective manner possible. Therefore, the program will address the identified consumer need and preference, obtained through the Person Centered IPP process and individualize and customize services and supports, rather than trying to "fit" the consumer into a previously established program.

Consumers, regardless of the level of functioning, are eligible for supported living services.

Supported Living is **NOT** Independent Living. Although there are similarities and crossover services, the two (2) programs are clearly different, and one should not be confused with the other. Supported Living Service is *not* time limited as is Independent Living.

II. Criteria

The Service Coordinator shall obtain a review with recommendations for referral to Supported Living from the Planning Team, which must include the appropriate consultant(s), prior to submission of funding request. The type and amount of support shall be based upon a consumer's assessed needs. Such needs should relate to success in living in a minimally restrictive environment. An initial assessment [i.e. no more than 10 hours] and ongoing services shall not exceed the monthly maximum allowed. The IPP Planning Team, after consultation with vendor, should indicate on the authorization, the number of hours per month needed for each consumer and not merely indicate the maximum hours allowed. This will avoid encumbering unnecessary funds.

III. Procedure for Review

The Service Coordinator shall convene the Interdisciplinary Review Team for a review thirty days after the consumer has moved into the Supported Living situation and shall complete the "Six Month Review of Supported Living Services (including comments describing strategies for addressing items not being met by the vendor)." If major problems are identified, the Service Coordinator shall convene another meeting of the Interdisciplinary Review Team, including Community Support Unit staff as needed to develop a plan to address the identified problems.

FUNDING STANDARDS
Family Life Skills Education

FAMILY LIFE SKILLS EDUCATION

Service Codes: 102 – Individual or Family Training

I. Definition

Family life skills include all areas which deal with human sexuality, including attitudes, feelings and behaviors which affect interpersonal and intrapersonal relations.

Included in Family Life Skills Education are the following:

1. Rights and responsibilities
2. Male and female puberty
3. Social behavior
4. Human reproduction
5. Contraception
6. Sexually transmitted diseases
7. Marriage and parenting
8. Sterilization and abortion counseling

II. Criteria

Males and females of childbearing age, who have expressed an interest in such training.

III. Procedure

1. Service Coordinator should consult with Public Health Nurse for all consumers requesting Family Life Skills Education. The Public Health Nurse will provide the Service Coordinator with generic resources and/or vendors depending on the nature of Family Life Skills Education requested and/or needed.

2. The SC will be responsible for providing additional consumer information to the service agency when requested, after securing consumer/guardian consent.

3. After completion of service delivery, a report will be mailed to the Service Coordinator who initiated the referral. The Public Health Nurse will also receive a copy of the report and will then provide the Service Coordinator with additional input and/or resources when appropriate.

4. Any consumer 13 years or older may receive Family Life Skills services without parental consent. It is advisable, however, to involve the parents or caretakers in the decision making process whenever possible. In cases where guardianship has been awarded, the legal guardian must give written consent prior to service delivery.

5. All vendored Family Life Skill Education is time-limited in three (3) month intervals. Any continuation of service must be based on a Public Health Nurse Consultation.

6. All requests for sterilization and abortion are presented at a Planning Team meeting with the Consumer Rights Advocate in attendance. The Planning Team will explore and present available options to the family. SCLARC does not provide funding for these services nor does it serve to influence consumer/family decisions. Sterilization and abortion cannot be performed without consumer consent or a court order.

FUNDING STANDARDS
Parent Education Program

PARENT EDUCATION PROGRAM

Service Code: 805 - Infant Development
520 - Independent Living Program
605 - Adaptive Skills Trainer

I. Definition

Parent education is a structured means of teaching parents appropriate parenting skills based on developmental theory and cultural sensitivity. Examples of the program focus include:

Mother - child relationship
Basic health issues
Child care (bathing, feeding, safety, etc.)

These areas are addressed using child development principles and several models of intervention such as developmental, behavioral and educational.

II. Criteria

A. The following consumers may be referred by Service Coordinator for a parent education program (following assessment and determination of need):

1. Regional Center/High Risk consumers whose parents are developmentally disabled (D.D. parents who receive Regional Center perinatal services may be referred prior to eligibility determination of offspring).

2. Regional Center/High Risk consumers who have teenage parents.

3. Parents of two or more Regional Center/High Risk consumers.

4. Parents of Regional Center/High Risk consumers with a history of suspected child abuse/neglect.

5. Parents of Regional Center/High Risk consumers with a history of substance abuse.

B. The following factors may be considered in assessing family dynamics to determine the need for referral to a parent education program.

1. Assessment of basic parenting/caregiving skills: Does parent know how to bathe, feed, position, etc., the infant?

2. Nutrition concerns: Is the infant exhibiting failure to thrive symptoms - i.e., vomiting, constipation, poor weight gain, etc.? Is there adequate, balanced nutrition intake?

3. Assessment of parent-child relationship:

   a) Is infant held when fed?
   b) Is there poor eye contact?
   c) Is child not easily comforted when held?
   d) Does parent attempt to comfort child when he/she cries?
   e) Does parent talk to infant/child?

4. Assessment of home environment:

   a) Is home free from safety hazards?
   b) Is infant/child's play area safe?
   c) Does parent demonstrate poor judgment regarding safety issues?

5. Parents' ability to discriminate and respond to appropriate and inappropriate behaviors based on their understanding of normal child development.

   a) Is there consistency in the home, i.e., daily routine, parental attention, setting limits, etc.?
   b) Does parent constantly give in to the child?
   c) Is there any family conflict (i.e., sibling rivalry, outside interference)? How is it handled?

III. Procedures for Referral

A. Consultation with appropriate Clinical Staff, Occupational Therapist or Nursing staff.

B. To avoid duplication - consumer must not be receiving similar services from an Infant Development or Behavioral Program. I.D. Team staffing may be necessary to determine the most appropriate service for a child and his/her family, i.e., Infant development Program vs. Behavioral Intervention vs. Parent Education.

C. Services may be purchased for 16-20 hours per month for three (3) months. Service may be extended upon consultation with appropriate clinical staff.

D. Some High Risk consumers may require only a Parent Education program instead of an Infant Development Program.

E. Should a consumer require both an Infant Development and Parent Education Program, every effort must be made to coordinate services, preferably with the same vendor.

F. All alternatives must be explored - e.g. community and generic resources. Consult with the Family Resource Center for assistance prior to consideration of SCLARC funding.

TUTORIAL SERVICES

Service Code: 680 - Tutor

I. Definition

Tutorial Services are provided on a one-to-one basis by a credentialed teacher or other certified or licensed professional.

Activities provided are academically oriented with specific goals and objectives clearly outlined. Tutorial objectives should be directly linked to a consumer's level of adaptive/cognitive functioning and partnership with other academic institutions as supplemental support.

Examples of indentified objectives that may be considered for SCLARC funding:

1. Assistance and educational support to sustain post secondary education attendance.
2. Math and reading readiness skills for persons 18 years or older for specified programs.
3. Academic preparation for state comprehensive exams, Standard Achievement Test and college entrance exams.

Policy

SCLARC can no longer purchase tutorial services due to the changes in the law.

WIC §4648.5. (a) Notwithstanding any other provision of law or regulations to the contrary, effective July 1, 2009, a regional centers' authority to purchase the following services shall be suspended pending implementation of the Individual Choice Budget and certification by the Director of Developmental Services that the Individual Choice Budget has been implemented and will result in state budget savings sufficient to offset the costs of providing the following services:
(1) Camping services and associated travel expenses.
(2) Social recreation activities, except for those activities vendored as community-based day programs.
(3) Educational services for children three to 17, inclusive, years of age.
(4) Nonmedical therapies, including, but not limited to, specialized recreation, art, dance, and music.

(b) For regional center consumers receiving services described in subdivision (a) as part of their Individual Program Plan (IPP) or individualized family service plan (IFSP), the prohibition in subdivision (a) shall take effect on August 1, 2009.
(c) An exemption may be granted on an individual basis in extraordinary circumstances to permit purchase of a service identified in subdivision (a) when the regional center determines that the service is a primary or critical means of ameliorating the physical, cognitive, or psychosocial effects of the consumer's developmental disability, or the service is necessary to enable the consumer to remain in his or her home and no alternative service is available to meet the consumer's needs.

In the event that SCLARC may consider an exception, the request must be submitted to the clinical interdisciplinary team for review, possible assessment and approval. (Refer to exception policy in section 2510 of POS guidelines)

FUNDING STANDARDS
Transportation

TRANSPORTATION

Service Codes:
- 875 Transportation Company
- 890 Transportation Auto Driver
- 880 Transportation Additional Component
- 895 Transportation - Public Transit Authority, Rental Car Agency, or Taxi
- 425 Transportation - Family Member

I. Definition and Criteria

A. Transportation services are services that are required to allow the consumer to gain access to services as outlined in the consumer's IPP. Transportation resources include the consumer, consumer's family, paratransit, public transportation, Public Utilities Commission, and vendored transportation.

B. The Regional Center shall purchase transportation services only when the service is included in the consumer's IPP, the provision of transportation service is not the responsibility of any public agency which receives funds for providing the transportation service; and the provision of transportation is not part of the consumer's community-based day program (Cal. Code Regs. Title. 17, 58510.)

C. Children 0-3 years of age are eligible to receive transportation and related costs necessary for a child and his or her family to receive services pursuant to the Individualized Family Service Plan. To the maximum extent appropriate to the needs of the child, transportation services shall be provided in settings natural or normal for children of the same age who have no disability. On an exceptional basis, when the child cannot be transported by family members due to the family member's illness or disability, or via public transportation due to the child's disability, the Regional Center may provide funding through the use of a voucher or the lowest cost vendored provider. SCLARC will also request a sufficient written documentation from the family demonstrating that the family members are unable to provide transportation for the child (WIC §4648.35).

Parents of children 3-18 years of age are expected to provide transportation to appointments and activities. The local education agency is responsible for providing transportation to public or non-public school pursuant to an individualized education program plan. On an exceptional basis, if the child's disabilities prevent the use of

public transportation, or the family is unable to transport the child as a result of illness or disability, the Regional Center may arrange for transportation through the use of a voucher, purchased bus pass, or by a regional center vendor.

D. Adult consumers should be assessed to determine their potential for independent travel on public transportation or paratransit. If the consumer has demonstrated this potential, then mobility training should be provided.

E. The ability for the consumer to learn to drive, walk, or bicycle to destinations should be considered.

F. Generally, adults who are employed are expected to travel independently to their job or with support provided by a supported employment agency.

G. In those situations where an adult consumer lives with his or her family, public transportation must be explored before the Regional Center can purchase transportation for the consumer. When necessary, the Regional Center may provide vouchers for the family to arrange for private transportation. When no private transportation is available, the Regional Center may provide transportation via a vendored provider.

H. Residential care facilities are generally responsible for arranging and providing transportation to activities and appointments for their residents. Some may have entered into separate agreements with the Regional Center to receive funding for the transportation of residents to and from their day programs.

I. Generic resources for funding must be explored prior to the provision of funding by the Regional Center.

J. Please note that any vendored transportation provider must possess safety seats, auto liability insurance and meet all other criteria as required by law.

K. Parent/individual transportation providers must maintain and provide proof of a valid driver's license required for the vehicle being utilized to transport the consumer, and proof of adequate auto liability insurance.

L. Transportation shall not be purchased by the Regional Center on an incidental basis unless:

1. A minor consumer's parent has a medical disability or illness that prevents him/her from transporting the consumer.

2. The consumer's medical and/or physical condition prevents him or her from being able to utilize public transportation or requires the use of specialized transportation devices not available on public transportation.

3. The distance that the consumer must be transported and/or the frequency that the consumer must be transported places an unusual demand upon the parent and/or the person most involved in the provision of direct care to the consumer for transportation services.

II. Funding Procedure for Auto Driver/Family Member

After reviewing the criteria for purchase of transportation services, the SC will complete the Transportation Service Request (TSR) and forward it to his or her Program Manager for review, approval and processing.

If Transportation Auto Driver/Non-Family Member is being requested, the rates will be based on the following criteria:

A. If the transportation provider transports the consumer 20 miles or less, for at least 10 roundtrips, the rate is set at a specific amount per month per consumer

B. If the transportation provider transports the consumer 20 miles or more, for at least 10 roundtrips, the rate is set at a specific higher amount per month per consumer

Please note that these rates are effective if the consumer who is being transported has at least 10 round trips per month; **otherwise**; the rate for transportation is half of the 10 round trips amount paid per month. The same applies to when the trips are less than 20 miles which would involve a similar reduction.

Service Coordinators should explore with the consumer, parent/family, or caregiver other possible sources of transportation before requesting Regional Center funding.

Please note that life and death situations requiring emergency transportation should always be referred to 911.

Along with mobility training and the family providing transportation, other possible alternatives include generic resources.

TRANSPORTATION – BUS PASSES

Service Code: 895 - Transportation - Public Transit Authority, Rental Car Agency, or Taxi

Parent Bus Pass

Service Coordinators are encouraged to explore various options to facilitate consumers' participation in their primary day program other than the use of traditional vendored transportation carriers. This may include the purchase of a bus pass for a parent, caregiver, or someone identified in the consumer's circle of support, for the purpose of escorting the Adult consumer to his or her primary program or job site.

Once it has been determined that a bus pass would be appropriate, but the parent/caregiver does not have the resources to purchase a bus pass, the Service Coordinator completes a Transportation Service Request (TSR) form and submits the form for approval and forwards it to Administrative Services for final processing. Once the bus pass has been processed, it will be mailed to the consumer each month by the Regional Center.

Consumer Bus Pass

Consumers may purchase reduced fare identification cards via the Los Angeles County Transit Operators Association (LACTOA) Reduced Fare Program.

Service Coordinators may facilitate the purchase of a reduced fare identification card and bus pass by a consumer capable of utilizing public transportation by assisting the consumer with the following:

a) A consumer must provide verification of a disability by submitting proof of SSI eligibility and Section I of LACTOA application to any participating LACTOA agency (see listing below to receive a reduced fare identification card. There is a small application fee.

b) If a consumer is not receiving SSI, SCLARC's psychologist can certify that the consumer has a developmental disability.

c) Once the reduced fare identification card is received, the consumer can purchase a bus pass at any local MTA outlet. MTA may be contacted to determine the locations of outlet stores. Please be

reminded that bus passes may also be purchased via the use of CITYRIDE scrips.

TRANSPORTATION – PARATRANSIT SERVICE

Service Code: 895 Transportation - Public Transit Authority, Rental Car Agency, or Taxi

Access Services Incorporated

Access is a paratransit service that provides limited services to disabled individuals who are not, because of their disability, able to utilize regular transit services. Consumers must register with Access in order to be eligible for services. The registration process takes approximately two to three weeks. Once the consumer is registered, Access should be contacted in advance to schedule a pickup date and time. Riders must pay with exact cash with a coupon scrip.

Coupon scrips are available for purchase from Access. Consumers may purchase a book of coupons that include 20 tickets. Consumer may contact the coupon department at Access services 1-800-827-0829 or any additional information.

CITYRIDE Program

CITYRIDE is a transportation service funded by Proposition A, Local Transit Assistance (PALTA) funds and administered by the City of Los Angeles Department of Transportation with the assistance of the Department of Aging.

CITYRIDE is a program for individuals in the City of Los Angeles, aged 65 or older and for qualified disabled persons. As a CITYRIDE registrant, you may purchase a book of 84 transit scrip once quarterly and use them to obtain Metro monthly bus pass stamps and discounts on city-permitted taxi and CITYRIDE Dial-A-Ride services. The transit scrip will expire on June 30 of each year.

To be eligible for CITYRIDE, you must be aged 65 or over, or have a mobility impairment and live in the City of Los Angeles or portions of the following Los Angeles County unincorporated areas: Kagel Canyon, Calabasas, Topanga, Marina del Rey, and areas near Carson and Long Beach.

City of Los Angeles Residents
CITYRIDE members living in the City of Los Angeles may use the scrip to purchase Metro Senior/Disabled Monthly Pass Stamps, Cityride Lift-Van Dial-a-Ride services, and City-franchised taxi services.

Los Angeles County Residents
CITYRIDE members living in the unincorporated areas of the Los Angeles County (Kagel Canyon, Calabasas, Topanga, Marina del Rey, and areas near Carson and Long Beach) may use the scrip for Cityride Lift-Van Dial-a-Ride service and City-franchised taxi services only.

CITYRIDE Contact Information: 213, 310, 323 or 818 area codes **808-RIDE (808-7433)**

MOBILITY TRAINING

Service Code: 650 – Mobility Training Services Specialist

I. Definition

Mobility training, also know as travel training, consists of individually planned activities and instruction which enables the consumer to utilize the most normalizing independent transportation modes possible, such as public transportation. The service is designed to assist the consumer in becoming more independent in his or her local community.

Training usually takes place for approximately three to six months and focuses on safety issues, routes, appropriate social behavior, and the use of bus tokens and passes, as well as other issues determined by individual consumer need.

II. Criteria

A. SC assesses the consumer's overall potential for travel training by reviewing the following factors:

- Is he/she able to communicate with people?
- Does he/she have the ability to respond in an emergency situation?
- Does he/she have the ability to use the telephone?
- Can he/she recognize and understand the use of tokens or a bus pass?

- With training, could he/she make a good judgment about the safety of crossing the street?
- Is he/she mobile?
- Is he/she willing and interested in learning to travel independently?

B. SC discusses with the consumer and family the types of training opportunities available and the objective of independent travel training on the public bus system.

C. Upon agreement with the consumer/family, SC reviews available mobility training resources and obtains a evaluation.

Forms

SOUTH CENTRAL LOS ANGELES REGIONAL CENTER
AUTO DRIVER/FAMILY MEMBER TRANSPORTATION AGREEMENT

I/We acknowledge that effective _____ I am/we are assuming the responsibility of arranging for the transportation of _____ to and from his/her regularly scheduled program. I/we also acknowledge that SCLARC is not liable and does not provide any insurance coverage for such transportation. I/We agree to make every reasonable effort to see that he/she arrives at the scheduled pick up time. I/We also certify by signing this agreement that the individual transporting the consumer maintains a current California driver's license, appropriate for the type of vehicle driven, and that I have adequate automobile insurance coverage, for the transportation which is the subject of this agreement

Name _____ Name: _____

Signature: _____ Signature: ____

Social Security #: _____ Social Security #: _____

Date: _____ Date: _____

Regional Center Use Only
Consumer UCI#: _____
Consumer DOB: _____

Revised: 12/07

SOUTH CENTRAL LOS ANGELES REGINAL CENTER
AMNIOCENTESIS REFERRAL

Language Spoken: _____ Date: _____
Previously seen at SCLARC: ☐ Yes ☐ No SCLARC #: _____
If yes, give date: _____ Private Ins.: ☐ Yes ☐ No
Medi-Cal: ☐ Yes ☐ No If yes, give name of carrier: _____

Client's Last Name	First	Middle	Age	DOB
Address		City	State,	Zip Code
( )	( )		( )	
Home Phone	Business Phone		Message Phone ( )	
Father's Name	Age	DOB	Phone	

REFERRED BY:
Name: _____ Telephone No: (____)_____

Agency: _____Address: _____City _____Zip _____

REASON FOR REFERRAL:

☐ Maternal Age > 35 By Due Date
☐ Prev. Child with Genetic Abnormality
Type of Abnormality _____
☐ Carrier of Chromosome Translocation
☐ Mother is a carrier of an X-linked genetic disorder
☐ Parents are carriers of recessive genetic disorders which are prenatally diagnosible
☐ Other (Explain) _____

TYPE OF PRENATAL DIAGNOSIS:

☐ Amnio ☐ CVS
☐ Ultrasound

LMJP: _____ **EDC:** _____ _____
G P SAB TAB STBN

Blood Type _____**RH** _____

OB / GYN (Name & Address): _____
Prenatal Diagnosis Scheduled: _____
Where Date Time

GENETIC COUNSELING & FUNDING APPOINTMENT: _____

FUNDING APPOINTMENT ONLY: _____

COUNSELOR: _____

DDS Approved 10/18/2010

SOUTH CENTRAL LOS ANGELES REGIONAL CENTER
PSYCHOTHERAPY/BEHAVIOR INTERVENTION REFERRAL

To make a referral for a Psychotherapy or Behavior Intervention, please call Bruce Williams, Ph.D., at (213) 744-8836, or mail this form to: Dr. Bruce Williams, South Central Los Angeles Regional Center, 650 West Adams Boulevard, Los Angeles, CA 90007. Please attach the most current psychological evaluation, IPP, IEP (if appropriate), report of any previous therapeutic interventions, and other material which is relevant to the presenting problem and treatment.

CONSUMER'S NAME: UCI#: _____ DOB: REFERRAL DATE:

RESIDENCE NAME/ADDRESS: PHONE:

RESIDENTIAL CARE PROVIDER(S): LANGUAGE(S):

DAY PROGRAM/SCHOOL PHONE:

DAY PROGRAM/SCHOOL ADDRESS:

TEACHER/SUPERVISOR/COUNSELOR:

S.C.: SC PHONE

Cognitive Functioning:
☐ Borderline ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Types of Impairment:
☐ Mental Retardation ☐ Cerebral Palsy ☐ Autism
☐ Etiological Syndrome (list): _____
☐ Mental Health Diagnosis (list): _____
☐ Physical Impairment (list): _____
☐ Seizures (list): _____
☐ Other (list): _____

Receptive Communication: ☐ understands simple instructions ☐ does not understand simple instructions

Expressive Communication: ☐ Non Verbal ☐ Low Verbal ☐ Verbal

Languages:

Alternative Communication system (list):

Problem Behaviors: (Put "1" if problem is mild, put "2" if problem is severe.)
☐ Aggressive ☐ Depression ☐ Destructive ☐ Hallucinations or delusions ☐ Hyperactive ☐ Resistive
☐ Inappropriate sexual behavior ☐ Insomnia ☐ Non-compliant ☐ Obsessive/compulsive ☐ Pica
☐ Runs away ☐ Self-injurious ☐ Smears feces ☐ Tantrums ☐ Verbally abusive ☐ Withdrawal

DDS Approved 10/18/2010

Other Problems (list): _____

_____

_____

Current Medications ☐ Yes ☐ No (IF YES, LIST TYPE AND DOSAGE BELOW)

_____

_____

Psychiatric: Is consumer currently in psychiatric treatment? ☐ yes ☐ no

If yes, list psychiatrist and phone number:

_____

Has consumer had previous behavioral or other mental health intervention: ☐ yes ☐ no

If yes:

1. name of provider/therapist:

   _____

2. phone number of therapist:

   _____

3. dates of intervention: from _____ to _____

4. brief statement of outcome:

   _____

_____

Additional Comments: _____

_____

_____

South Central Los Angeles Regional Center
for Persons with developmental disabilities, inc.

650 W. Adams Blvd., Suite 200
Los Angeles, California 90007
Ph: 213.744.7000
Info Line: 1.866.4.sclarc
TTY: 213.763.5634
www.sclarc.org

Referred by:_____
Name:_____
Phone:_____
Date of Referral:_____

SOUTH CENTRAL LOS ANGELES REGIONAL CENTER
GENETIC REFERRAL FORM

CONTACT PERSON:_____

IDENTIFYING DATA:

SCLARC#:

Consumer Name: Birthdate:

Parent(s) Names: Birthdate:

Birthdate

Mother's Maiden Name:

Ethnicity: Mother:_____ Father:_____

Address:

(City) (State)
(Zip Code)

Language Spoken:

Telephone Number: ( )

If family is bi-lingual, which language is predominant?

Cytogenetic or Genetic Consult Reports are available from:

Name:

Address:

(City) (State)
(Zip Code)

GENETIC REFERRAL
PAGE TWO

REASON FOR REFERRAL

High-Risk Parent(s):

_____ Mother who will be thirty-five years or older at the time of delivery.
_____ Mother who has a history of two or more spontaneous abortions.
_____ A mother who has already given birth to a baby with a birth defect or mental retardation
_____ Parents who are known carriers of a genetic disorder.
_____ Parents with a history of hereditary disease.
_____ Parents with a family history of a genetic disorder.
_____ Women who are consumers of drugs or alcohol.

High-Risk Family:

_____ Child Bearing Age Siblings.
_____ Extended Family Members.

Clinical:

_____ Unusual Physical features
_____ History of corrected birth defects.
_____ Family history of mental retardation.
_____ Family history of a hereditary disease.
_____ A genetic condition or a birth defect which is known to recur in families, i.e. spina bifida, etc.

OTHER

_____

_____

Service Requested: (Check as many as apply)

_____ Genetic counseling for primary or secondary consumer.
_____ Diagnostic evaluation for consumer or family member.
_____ Information for SCLARC staff.
_____ Other:

/cl 8

SOUTH CENTRAL LOS ANGELES REGIONAL CENTER
FOR DEVELOPMENTALLY DISABLED PERSONS, INC.

REFERRAL FORM FOR NUTRITION SERVICE

Name of Consumer: BD: RC#:

Consumer's Address: Phone:

Responsible Person: Relationship:

Diagnosis:

Reason for Referral: Height: Weight:

School/Day Program:

Contact Person (Program): Phone:

Other Pertinent Information (family support, emotional state, medical, etc):

Do you wish to be present at time of evaluation? ( ) Yes* ( ) No *Available Time:	Status of Request: ( ) Urgent (less than one week) Due:
Action Taken:	( ) Routine Due:
	OR
	Date of Next Review:
	Service Coordinator:
	Unit: Date:

INSTRUCTIONS: Staff members requesting consultation will complete this form and forward to the Specialist.

NOTE: Service Coordinator should:

- Discuss referral with family and/or other providers of service as warranted.
- Specify problem and/or requested service.
- Document/referral in an I.D.Note.

04/14/04
cl\Forms\Nutritional Referral.doc

DDS Approved 10/18/2010

SOUTH CENTRAL LOS ANGELES REGIONAL CENTER

OCCUPATIONAL THERAPY REFERRAL

Consumer's Name:	Date:
DOB:	SC:
UCI #:	SC Phone #:
Diagnosis:	

Parent/Guardian:
Address:
Telephone #:

CCS:	Yes:	No:	Date of Referral:	Date of Denial:
Medical:	Yes:	No:	Date of Referral:	Date of Denial:

Request for: OT Consultation/Recommendation ☐ Equipment Needs ☐
Team Meeting ☐ Family Meeting ☐
OT Evaluation/Screening ☐ Site Visit ☐

Areas of Need: Developmental		Adaptive Equipment	
Fine Motor		ADL/Self Help	
Gross Motor		Community Program	
Neuromuscular		Functional Mobility	
Oral Motor/Feeding		Home Program	
Perceptual/Visual Motor		Position/Handling	
Physical Limitations		Prevocational Training	
Sensory Integration			

Reason for Referral:

Previous OT and/or other therapeutic interventions:

Current OT services, other therapeutic interventions and/or program and locations: