TABLE OF CONTENTS

I. Introduction

II. Philosophy and Definition

III. Building Interdependence
   A. Housing
   B. Supports
   C. Networking

IV. Regional Planning & Development

V. Referral, Assessment, and Planning
   A. Introduction
   B. Flow Chart
   C. Process

VI. Financial
   A. Review of Funding Mechanisms
   B. Rate Setting
   C. Contracting & Subcontracting
   D. Authorization
   E. Fiscal Tracking

VII. Quality Assurance
   A. Licensure
   B. Accreditation
   C. Program Evaluation
   D. Consumer Review
APPENDICES

A. Clinical Criteria for Residential Services
   Comprehensive Services Model

B. ISL Residential Budget Plan & Directions
   Combined Sources Support Plan

C. Qualified Mental Retardation Professional - Definition

D. References
CHAPTER I

INTRODUCTION
CHAPTER I

INTRODUCTION

One might well ask, "Why develop another residential option?". The impetus has truly come from the people we serve. How often have we heard statements like "I want to live in an apartment" or "I want a place of my own"? Case managers and providers in various parts of the state have listened to and acted on the wishes of the individuals they serve. They have helped people find apartments or small homes and have provided supports to them in those settings. This is the essence of individualized supported living.

It is important to note that Individualized Supported Living is not just another option in the continuum. It is a new way of looking at how we afford the opportunity for community living to people with disabilities regardless of their competency, the severity of their disabilities, or the degree of physical or behavioral challenge.

Individualized Supported Living is, in fact, becoming a national movement. Several states including Wisconsin, North Dakota, and Washington have offered supported living as a residential option for people for several years. The Missouri Planning Council included supported living in the long range plan for the state. This body has now endorsed the use of Individualized Supported Living for Missouri's citizens with mental retardation and developmental disabilities.

In fact, some of the impetus for supported living has grown out of difficulties inherent in the existing community placement continuum. Some of these difficulties are programmatic in nature. Existing placement options are designed with a specific kind of person in mind. Problems occur when the individual does not 'fit' into the existing model. Conceptually the continuum suggests a series of graduations from most to least restrictive settings. Unfortunately, there are not always openings nor is there always funding to allow the 'graduation' to occur. The continuum relies on a train and place model. However, many of the areas in which the individual is trained (Ex., how to use appliances, bus routes, etc.) may require retraining when the individual moves. Some of the difficulties with the continuum are more provider related. Some have expressed the need for a more flexible and responsive system. Yet the provider requires some stability of funding in order to afford continuity in both quantity and quality of service delivery.
The Division of Mental Retardation and Developmental Disabilities wanted to provide an alternative to the continuum based model. A task force was commissioned to address these concerns in a manner which emphasized responsiveness, choice, flexibility, and individuality. The Individualized Supported Living model discussed on the following pages reflects the product of this effort.

The Department of Mental Health, Division of Mental Retardation and Developmental Disabilities shall limit what it defines as supported living to situations like those described in the following pages. Any exceptions shall require the prior written approval of the Director of the Division of Mental Retardation and Developmental Disabilities.
CHAPTER II

PHILOSOPHY AND DEFINITION
CHAPTER II

INDIVIDUALIZED SUPPORTED LIVING

PHILOSOPHY AND DEFINITION

PHILOSOPHY: Individuals with developmental disabilities have a right to make responsible decisions consistent with the choices afforded non-disabled citizens. These decisions include within attainable means, living in homes and neighborhoods of their choice with persons of their choosing. These settings and life styles will allow people to pursue their own interests, express their individuality, and actively participate in their communities. To exercise these rights, individuals with developmental disabilities may need uniquely individualized assistance.

DEFINITION: Supported living is a coordinated system of supports centering around the individual, designed to facilitate each person's choices to live, work, learn, and actively participate with non-disabled peers in the community. These supports might include training, protective oversight, physical assistance, or environmental adaptations. Individuals with developmental disabilities, regardless of their level of competence or degree of physical or behavioral challenge, can benefit from supported living.

This system of support requires a shift from the current approach of viewing residential services as movement through a "continuum". A "continuum" presupposes that people will be taught skills in one environment to prepare them for movement to the next step in the "continuum".

** Graphics adapted from: Current Issues in Community Residential Services for People with Developmental Disabilities - July, 1988, Links, Pages 19-21 Derrick Dufresne
In contrast, the supported living concept focuses on the individual. Intensity and variety of services and supports will fluctuate over time, allowing for decreases as skills are learned and as natural supports become operative. Support can increase as stress, major life changes, or other circumstances occur. Therefore, relocation for the purpose of accessing most services becomes unnecessary. People may choose to relocate for better housing, employment opportunities, or health as do their non-disabled peers.

**PRINCIPLES/CHARACTERISTICS:**

Individualized Supported Living is characterized by creativity, flexibility, responsiveness, and diversity as reflected by the following:

1. People live and receive needed supports in the household of their choice which might include their family home, an apartment, condominium, or house in settings typical of non-disabled peers. The selected housing should represent an adequate standard of living common to other citizens, allowing for reasonable protection and safety.

2. Personal preferences and desires of those served are respected. Personal autonomy and independence are promoted. Individuals receiving services participate in the planning, operation, and evaluation of services. The participant's self-direction and control leading toward self-governance are maximized through services rendered.

3. Existing generic resources and natural supports, paid and unpaid, are maximized from the community at large.
4. Training focuses on acquiring functional, useful skills within the community. Services minimize the need for skill transfer by providing training in the environment in which the skills are required.

5. Services are "outcome" focused, addressing the quality of life being experienced in the present life style and not in the potential future implied by skill development/attainment.

6. Services are provided based on individual needs not predicated on inflexible restrictions of specific funding mechanisms.

7. Service goals are directed toward participation in the life of one's own community. As with any other citizen, this involves individual participation in civic activities and joining community organizations assuming those roles which are valued by the community.

THE SUPPORTED LIVING MODEL AS CONTRASTED WITH THE CONTINUUM BASED MODEL:

1. The separation of the components of housing and support services as contrasted with the traditional approach of requiring a person to live in a certain facility type in order to receive a given intensity and type of support.

2. Preference will be given to existing, integrated community housing as contrasted with housing constructed or renovated for single use or populations.

3. Individual responsibility and ownership as contrasted with agency assumed responsibility.

4. Increased use of generic services as contrasted with specialized agencies providing all services.

5. Certifying or accrediting agencies or support personnel as contrasted with physical plant/facility licensure.

6. Flexibility in hours of service intervention and staff support to individuals as contrasted with fixed staffing patterns and agency standardized service intervention.
7. Variety in provision of staff and other forms of support, both paid and unpaid, (i.e., live-in staff, roommates, companions, neighbors, adaptive equipment, emergency on-call systems) as contrasted with professional or para-professional staff employed, paid and supervised exclusively by the agency.

8. Individually determined funding and reimbursement methodology as contrasted with a facility based approach.

9. Intensity of support based on individual's needs as contrasted with the group.

10. Using the functional assessment process to determine the preferences of and supports needed by the individual as contrasted with screening in and out of services, i.e., preset admission/discharge criteria.

11. Developing supports for people with varying levels of competence in their homes as contrasted with preset facility types based on diagnosis.

12. The number of unrelated people with disabilities living together shall not exceed three (3). Ideally, the number of persons in a given neighborhood should not exceed the prevalence of individuals with disabilities within that community as contrasted with preset facility-type capacities.

13. Creatively supporting a person in an existing environment as contrasted with each living environment providing the training a person needs to progress.
CHAPTER III

BUILDING INTERDEPENDENCE
CHAPTER III
BUILDING INTERDEPENDENCE

The first prerequisite to building interdependence through the use of generic resources is a change in philosophy. A critical shift occurs when it is recognized that interdependence, not independence, is the goal.

Interdependence implies reciprocity. This can be seen in the give and take of human relationships. Relationships entail a mutual dependence which involves reliance on others and requires a complimentary dependability on both parts.

The concept of interdependence also extends to the environment. We are expected to act in a relatively normative fashion with respect to specific settings. Environments can also be designed for the explicit purpose of aiding adaptation. This results in a complimentary relationship between the individual and their environment.

How is interdependence built through the use of generic resources? When one service provider is relied upon to meet all the needs of an individual, as has been done in the past for individuals living in licensure regulated, DMH funded settings, the individual is restricted to the options available through that provider of service.

Through the use of generic resources the lives of individuals with disabilities are enriched through opportunities, choices, and relationships. Opportunities to interact with non-disabled members of the community increase and opportunities for experiences in non-segregated settings expand. Informal quality assurance systems develop naturally as more people become involved in the lives of individuals with disabilities. At the same time, natural support systems and advocacy networks can develop.

Another critical shift occurs with the realization that real estate is separate from services and that housing is separate from supports. The brokering of services is integral to supported living.

When these critical shifts occur, doors open to individuals with disabilities. Specific examples of the implications of these principles follow.
HOUSING

As soon as individuals leave group settings and move to homes of their own, changes begin to take place in their lives. Individuals can make more independent decisions about activities in their homes and lives.

Possibilities for non-DMH generic housing may include:

- Family homes where an individual remains a part of an intact family structure or has a portion of the home as their own quarters;

- Purchased property owned by the individual with disabilities is a realistic option through subsidized loans such as those provided by the Farm Home Administration or through low-interest fixed-rate loans such as those available through the Missouri Housing Development Corporation;

- Property purchased through cooperatives involving two or more individuals;

- A life-lease which allows occupancy until the individual's death when the property reverts to other heirs;

- Rental homes or apartments leased or rented through typical landlords;

- Existing HUD apartments (202) and rent subsidies to landlords.

SUPPORTS

* Personal care, attendant and homemaker services: Utilization of these generic services allows some individuals with disabilities an opportunity to live in a home of their choice which, without such supports, might not be a viable option. These services may be reimbursed through a variety of funding sources (SSBG, POS, Title XIX). Benefits include more privacy and more opportunities for choice of their care providers.

* Adaptations to the Environment: Environmental adaptations allow for greater freedom and privacy, as well as peace of mind, not only to the individual served, but also to families and others involved in the life of the individual. Often an individual's home can be modified to be accessible for a relatively modest cost. Other examples include telecommunication devices for the deaf, tactile alarm signaling systems, and hospital life lines.
* Transportation: Generic transportation can sometimes be accessed through city transit lines, locally provided transportation services, car pools, cabs, friends, neighbors, family members, or fellow club and church members. Transportation through generic sources continues to be a very challenging issue in some localities. Continued utilization of specialized services does not allow development of solutions to transportation problems or provision of alternative, more integrated services.

* Public Education Resources: There are numerous examples of services already available. They include public schools (GED, technical/vocational, adult classes); higher education (adult continuing education); public health (nutrition, maternal child care, basic health); and planned parenthood for sexual education.

* Recreation and Leisure: Individuals with disabilities can participate in generic community resources for recreation and leisure by becoming members of town-league softball teams, local bowling leagues, garden clubs, church groups, etc., and by participating in sewing circles, dances, sporting events, theatre groups, and by contributing to volunteer projects within the community.

* Goods and Services: As customers and consumers using the same community services nondisabled peers use for shopping, banking, restaurants, entertainment, and worship, individuals with disabilities begin to exercise their citizenship within the community at large and experience many of the same benefits and opportunities enjoyed by their nondisabled peers.

**NETWORKING**

Successful networking begins with a comprehensive knowledge of the individual to be served. What are his desires, preferences, interests, and abilities, and what supports may be needed to allow him to live in a home of his choice? Knowledge of the resources available within a given community, as well as skills in relating to those individuals in positions to provide these supports and resources are essential. Networkers must be capable of educating generic resource providers regarding ways in which individuals with disabilities can become customers and consumers of their resources and supports. Commitment on the part of networkers and service coordinators to seek the maximum use of generic resources is critical.

Identification of needed supports can be accomplished by considering the individual first through assessment of preferences, needs, and environments. The system of supports (many of which are available through generic resources) is then designed around the individual.
EDUCATION

Education should be an individualized approach. This may include discussion of the Individualized Supported Living concept and discussion of supports which will safely and adequately meet needs. Methods may include site visits, video tapes, slide presentations, etc. Education may include the person, family and significant others.

FOLLOW ALONG

It is necessary that there be assistance available in solving day to day problems as long as required by the individual. Interaction and communication between those involved help to build a network of support that will withstand the inevitable challenges.

SUMMARY

While networking involves a change in approach for human service workers, it provides a mechanism which allows facilitation of the interdependence of the individuals within the larger community. Through the creation of a well developed network of supports, individuals can become part of their communities.
CHAPTER IV

REGIONAL PLANNING & DEVELOPMENT
CHAPTER IV
REGIONAL PLANNING AND DEVELOPMENT

It is expected that each region will maintain an ongoing needs assessment process. This process should involve identification of specific individual needs which should then be prioritized in accordance with the Official Directive on Clinical Criteria for Residential Services and the Division's Comprehensive Services Model. (See Appendix A). Staff responsible for development at the Regional Centers should be aware of needs assessment data and resultant development priorities.

Regional Plans should be based on this needs assessment data and reflect priorities as established through this process. Centers are strongly encouraged to reflect Individualized Supported Living rather than facility based models in their regional plan for new development using CPP funds. This would promote consistency with the 1990 Report "Missouri at the Crossroads" developed by the Missouri Planning Council. Consequently, state budget sheets (Form Vs) for new development would reflect individual needs as implemented through the ISL model.

The Regional Center would recruit potential lead agencies. Unlike the traditional Department of Mental Health community placement facility based model, the ISL model will not provide assurances to potential lead agencies that they will be serving a specified number of individuals. (See Chapter VI: Selection of Providers for further information.)
CHAPTER V

REFERRAL, ASSESSMENT, AND PLANNING
CHAPTER V

REFERRAL, ASSESSMENT, AND PLANNING PROCESS

Referral for supported living can come from the individuals we serve, parents, friends, providers, staff, or other agencies. Referral could grow out of the assessment or IHP process.

As there is diversity in the referral itself, there will also be differences in the internal regional center process. It is recognized that these differences will continue dependent on a variety of factors including normal operating procedure for any given region and availability of provider agencies. The material that follows is intended to capture the kinds of functions that are performed rather than mandating who is to carry out these functions.

The concept of a lead provider or lead agency grew out of the importance of having some one person or agency provide case coordination functions. This is critical in thinking about supported living. Given that individuals will be receiving services and benefiting from many community supports it is imperative that responsibility for intensive case coordination be assigned.

In order to offer this service as a part of the Medicaid Home and Community Based Waiver, a provider must be selected to serve as the lead provider. This provider must have the capacity to offer case coordination, direct service provision, and other lead resource functions described in this document. In some regions where there are viable agencies such as county boards, the Regional Center may reach an agreement with that agency to become the Individualized Supported Living provider and perform designated lead provider and case coordination functions.

In other parts of the state, there may be no agency within any given county that could reasonably assume such functions. In that case, the Regional Center, with the approval of the Division Director, may become the lead agency or lead provider. However, the ISL service shall not be waivered under these circumstances.

It is recognized that this diversity will continue. The issue becomes one of clearly delineating responsibility for these functions so that the individual remains in a secure situation. It should be remembered that the service cannot be waivered if the Regional Center serves as the lead agency/lead provider.
As such, the following material spells out functions in the referral, assessment, and planning process. The flow chart and narrative utilize the terminology lead provider. As stated above, these intensive case coordination functions may be assumed by a lead provider or, with Division Director approval, by the regional center itself. There may also be some situations in which these responsibilities are shared.
SUPPORTED LIVING

REFERRAL, ASSESSMENT AND PLANNING PROCESS

REQUEST

REGIONAL CENTER STAFF

IHP OR IHP REVIEW OR INITIAL SERVICE PLAN

LEAD PROVIDER

REFERRAL FOR SUPPORTED LIVING

GATHER INFORMATION

FUNCTIONAL ASSESSMENT

IHP REVIEW OR IHP/PERSONAL FUTURES PLANNING

SUPPORTED LIVING BUDGET

PLAN AND BUDGET APPROVAL

IMPLEMENTATION OF PLAN

SUPPORTED LIVING PLAN

ONGOING REVIEW

July 1, 1990
INDIVIDUALIZED SUPPORTED LIVING

REFERRAL, ASSESSMENT AND PLANNING PROCESS

1. Referral

   A. The request for support services can be made by Regional Center staff, the family, friends, the individual, or an agency.

   B. The Regional Center shall offer the individual a choice among lead providers based on the IHP review or initial service plan. The Regional Center shall then make a referral to the lead provider of the individual's choosing.

   Under the Medicaid Home and Community Based Waiver, the lead provider/agency shall be a Medicaid Waiver provider. For individuals not participating in the MHCBW, the lead provider may be a recognized contractor of the Department of Mental Health, the Regional Center itself, or a county board under inter-governmental agreement.

   The lead provider shall be responsible for the overall systematic development of the IHP which includes the supported living plan. The lead provider will assume responsibility for case coordination and implementation of the supported living plan. They will provide a 24 hour crisis phone line, coordinate all community supports, and assure that services are delivered as planned. They will maintain family contact as appropriate and will assist the individual in making desired moves or changes. The lead provider shall monitor overall delivery of supports, seek additional avenues of support as needed, and act as the individual's advocate.

   Missouri's case management system will continue to follow individuals served through this program according to standard operating procedure. For those individuals participating in the MHCBW, state case management staff will make monthly visits to assure quality of care, to assess continued need for services, and to determine whether services provided are meeting the individual's needs.

(LEAD PROVIDER)

2. Gather and Organize Information

   A. The process for gathering information should include:

      - Observation of the individual in various environments and daily activities.
- Interviews with the individual and significant others.
- Review of previous evaluations, history and IHP.

B. In preparation for the planning process and to identify areas in which an individual might need support, the following methods for organizing the information are suggested:

- Recording information on an individual profile.
- Development of a "week at a glance" calendar delineating a typical week's activities. This may be beneficial in identifying critical time periods for formal and informal supports.
- Development of an environmental composite delineating the places, hours and activities in which an individual is engaged. This may be beneficial in determining a balance in life activities.

C. Reference materials which may be of assistance in this process include the following:

It's Never Too Early, It's Never Too Late: A Booklet About Personal Futures Planning. (Zwernik & Mount)

Belonging to the Community. Options in Community Living, Madison Wisconsin. (Johnson)

For complete reference, see Appendix C.

3. Functional Assessment

The process of determining what supports are needed must begin with functional assessment. Emphasis should be placed on identifying skills and supports required to maintaining an individual in their natural environment. Rather than identifying sequential learning objectives or readiness skills, emphasis is placed on practical, community-based skills learned in the environment.

4. IHP/Personal Futures Planning

The IHP is developed to facilitate Individualized Supported Living and may need to take advantage of new and innovative approaches such as Personal Futures Planning. This process involves the individual and all significant others in the
person's life. This is a brainstorming session where all possibilities and dreams are discussed. This process is described in a manual published by the Minnesota Governor's Planning Council on Developmental Disabilities and entitled, *It's Never Too Early, It's Never Too Late: A Booklet about Personal Futures Planning*. It provides a process complimentary to the HIP and can offer the following:

"A futures plan can help those involved with the focus person see the total person, recognize his or her desires and interests, and discover completely new ways of thinking about the future of the person. A futures plan can lead to organizational change. The habilitation plan can help workers organize their work, and it can establish accountability among agencies for the implementation of certain strategies. Together, the futures plan and the habilitation plan provide a more comprehensive and feasible approach to achieving the desired goals of the person." (Mount & Zwernik, 1988).*

5. **Supported Living Plan and Budget**

Describe the environment, staff intervention and needed supports (both formal and informal) in the following areas:

- Housing
- Employment
- Recreation/Leisure
- Social
- Physical and Mental Health
- Safety (Paid and unpaid staff support, mechanical aids)
- Mobility (personal/environmental)
- Communication
- Sexuality

Creativity is the key word in identifying supports. The Individualized Support Worksheet included in this chapter may be used to assist in this process. In all cases priority must be given to generic services to meet support needs. (See Chapter III).

## INDIVIDUALIZED SUPPORT WORKSHEET
### (OPTIONAL)

<table>
<thead>
<tr>
<th>LIFE AREAS</th>
<th>SUPPORT OPTIONS</th>
<th>CHOICE</th>
<th>RESPONSIBLE IMPLEMENTOR</th>
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<tbody>
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<td>Employment</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
Three (3) people with disabilities is the maximum allowable in any one living situation. Individual choice must always be considered and, whenever possible, prevail.

6. Supported Living Budget

The ISL Residential Budget Plan is completed based on the Supported Living Plan. (See Chapter VI).

7. Plan and Budget Approval

The Individualized Supported Living plan and budget shall be submitted to applicable funding source(s) for review and approval. Refer to Chapter VI for information regarding budget planning.

8. Implementation of Plan

The lead provider shall be responsible for implementation of the plan. Plan implementation includes: securing housing; securing supports and revision of the IHP in conjunction with the Regional Center. It emphasizes coordination across supports including the assurance that supports are effective and provided as planned. Missouri’s state case management staff will continue to closely monitor this process.

9. Ongoing Review

Wishes, desires, and needs will change over the course of time. The lead provider will be responsible for periodically reviewing and amending the Individualized Supported Living Plan. At that time it may be necessary to reconvene the team and revise and resubmit the Individualized Supported Living budget.
CHAPTER VI

FINANCIAL
CHAPTER VI
FINANCIAL

There is a need for individualization and flexibility in funding supported living arrangements. Individualized Supported Living has been designed to work as much as possible within the existing fiscal system. To do otherwise would require a far longer planning and implementation phase - perhaps years.

Review of Funding Mechanisms

Existing systems include the Purchase of Service system (POS) and the Community Placement Program (CPP). While on the surface the POS system appears more individually prescriptive, it has some limitations which include the following:

* There may be variations in POS allocations per fiscal year. Historically, POS funding has been vulnerable because the withholding of funding for these services has not been viewed as endangering the individual. Placement funding, on the other hand, is more protected due to the fact that loss of these funds would result in loss of a place to live.

* Unit rates vary as does the allocation itself. Varying rates and allocations produce changes in service levels.

* Varying approval levels produce instability for the individual receiving services and for the provider’s ongoing ability to respond to the needs of the individual.

* It would not be possible to assure families of the security of the living situation due to the instability of funding and fragmentation of service delivery.

* Use of POS funds for individuals in the Community Placement Program would further detract from funding available to people living in their natural homes for family support.

* Services could be fragmented across several agencies, each providing a different, discreet service to the same individual. There is no simple mechanism through which a lead provider could be established to provide continuity of services and ongoing review. As a result, no single provider would be responsible for assuring that the support service was delivered as prescribed.

* Provider recruitment for Individualized Supported Living would be problematic because of the existent problems inherent in POS.
There are limitations within the Community Placement Program also. Funding has been handled in a facility based manner. This has resulted in lowered flexibility, responsiveness, and individualization. This, however, is more a byproduct of placement philosophy than an artifact of the system. Establishing policy specific to supported living could enable us to use the CPP system as it stands now. This would have the advantage of offering much more rapid implementation than would development of an alternative system. CPP is stable and could be redirected through policy to allow flexible, responsive services without the drawbacks inherent in the POS system.

Assuming that the CPP system will be used to fund residentially related costs, a specific rate setting mechanism is needed. In order to accommodate the Medicaid Home and Community Based Waiver, that mechanism needs to result in the ability to separately establish a Room and Board rate and a Residential Habilitation rate. Given the whole philosophy of Individualized Supported Living, discussion of rate setting must begin with the individual and follow a course which remains responsive to the individual.

Selecting Providers

The selection of the lead provider for the ISL occurs during the development of the Supported Living Plan. In that individual choice must prevail in a supported living model, the selection of provider is exempt from state bidding requirements. The Regional Center may elect to issue a Request for Proposal as a means of identifying potential lead providers from which the individual may then choose.

Centers are strongly encouraged to reflect Individualized Supported Living rather than facility based models in their regional plans for new development using CPP funds. As appropriate, existing CPP funding may be redirected to Individualized Supported Living.

Rate Setting - Residential Component

Room and Board and Residential Habilitation rates need to be established. Room and Board will cover all housing related costs. Residential Habilitation will include residential training and support costs. Funding needed to provide case coordination across other service providers and community supports should be included in the residential habilitation rate. These two rates will be derived for all individuals, using the Individualized Supported Living Residential Budget Plan. (See Appendix B.)
Funding authorization periods will work in conjunction with the individual’s IHP. Initial Residential Budget Plans shall be in effect for 3 month periods and may be renegotiated monthly thereafter. In no event may Residential Budget Plans be extended longer than the duration of the IHP. Regional Centers will, however, plan for and set aside funding through the duration of any given fiscal year.

The Individualized Supported Living Residential Budget Plan and directions are included as Appendix B. Room and Board and Residential Habilitation rates and POS costs which are summarized on the IPC or Combined Sources Support Plan, may be approved at the regional level if requested amounts of Department of Mental Health funding do not exceed certain limitations. The Regional Center Director is authorized to approve combined Room & Board and Residential Habilitation rates that do not exceed $90 per day as per Official Directive. Limitations for future years will be based on funding allocations tied to Waiver at the Division Director’s discretion.

The DMR-DD will maintain a statewide average of all ISL contracts which does not exceed the federal Waiver cap for that fiscal year. Separate averages will be derived for Waiver and non-waiver participants. For example, if there are 10 waivered ISL contracts in FY ‘91, individual contracts may exceed the cap. However, in no case may the average of all ISL waivered services for the state exceed $112.89 per day ($41,207.00 per year).

Within the Individualized Supported Living Residential Budget Plan, staffing salaries and benefits are fixed. While the number of service hours may vary, the reimbursement rate remains constant for specific staff positions. This was done in order to reduce the amount of time required for review and negotiation. The budget plan should be able to be completed by the case manager and lead provider following development of the Individual Support Plan.

Contract

Having established a rate, a specific contracting mechanism is now necessary. Again, use of the existing system will promote ease of implementation. This necessitates differential contracting dependent upon whether the individual is participating in the Waiver.

If the individual is not participating in the Waiver, the Community Placement Services Master Agreement for Supportive Community Living (DMH 8503) will be used. Both the Residential Habilitation costs and the Room and Board costs would be added to the DMH 57 under the special services code established for use in Individualized Supported Living. The code is 41Y93W.
If the individual is participating in the Waiver, the Missouri Department of Mental Health, Community Placement Services Master Agreement for Room and Board under the Medicaid Home and Community Based Waiver (DMH-8819) would be used for the Room and Board cost. The Room and Board costs would be added to the DMH 57 system under code 41Y93W. The Purchase of Service Contractual Agreement for Medicaid Home and Community Based Waiver Services, Mentally Retarded/Developmentally Disabled, would be used for the Residential Habilitation costs. The code established for waivered Residential Habilitation costs provided under Individualized Supported Living is Y91019.

Subcontracting (NON-WAIVER ONLY)

For Waiver services, all staff must be employees of the provider agency. When service provision is non-waivered, the residential habilitation provider may wish to sub-contract with other persons or agencies to provide portions of the supports needed by the individual. For example, the individual may benefit from having a paid neighbor assist them in specific ways. The individual may require mobility training for which the residential habilitation provider subcontracts with an Occupational Therapist in the area. In these kinds of situations, the agency may choose to enter into a subcontractual agreement rather than actually hiring additional staff. A sample subcontract is available through the Division of Mental Retardation and Developmental Disabilities.

Please note that subcontracting of this nature cannot be used if the service is waivered. In this case, providers would be required to hire the persons providing supports.

Regional Center as Lead Provider/Agency (NON-WAIVER ONLY)

In non-waiver situations the Regional Center may, with the prior written approval of the MR-DD Division Director, choose to serve as the lead provider/agency. In coordinating the various supports the Regional Center may wish to write a letter of agreement spelling out the parameters of the relationship.

The Regional Center, in the role of a lead agency, shall establish specific qualifications which must be met by those providing support. Such requirements may include requests to attend training or to submit documentation regarding specific credentials. This shall apply to paid or unpaid staff.

Potential support providers shall be acceptable to the individuals served, be addressed on an individual basis, and reflect the same standards that other citizens at large would expect. These support relationships shall promote sound philosophical values and promote the rights and dignity of individuals served.
The Regional Center shall approve support providers through an interview and/or review process. Specific items requested for review will vary dependent on the nature of support needed. Some examples of possible requirements include the following:

- Prior substantiated abuse/neglect screening through DFS and/or DOA;
- Applicable licenses, degrees, or diplomas;
- References from former employers or others;
- CPR, First Aid, Regional Center approved medication administration, or other training as applicable;
- Health Reports (Example: Tuberculosis or Hepatitis tests);
- Valid Missouri Chauffeur’s License;
- Liability insurance;
- Police checks for convictions.

Specific minimal requirements have been established for persons performing certain functions. They are as follows:

(1) Function: Transportation

Requirements:
- valid Chauffeur’s License
- liability insurance
- prior substantiated abuse/neglect screening
- police checks for convictions

(2) Function: Care and/or Training:

Requirements:
- prior substantiated abuse/neglect screening
- TB/Tine Test
- references from former employers or others
- police checks for conviction
(3) Function: Medication administration or oversight of self-administration.

Requirements:

- RN or LPN and copy of license
- or
- successful completion of Regional Center approved medication administration training
  and
- all requirements for the care and/or training function

For other types of functions, the Regional Center will establish and document specific qualifications needed. Copies of documentation for individuals carrying out these functions will be retained at the Regional Center for at least five years following the discontinuance of the use of the specific provider or until litigation is resolved if in process.

Authorization

Having contracted, specific services will need to be authorized. Again, this will be handled differently dependent on whether the individual is participating in the Waiver.

If the individual is not participating in the Waiver, all residential related costs will be authorized through the Community Placement Funding Authorization (DMH 57). The Residential Habilitation costs will be placed on the ‘Specialized Services’ line of the DMH 57. The code for Individualized Supported Living for use on this line is 41Y93W. This will allow identification of authorizations issued for that purpose. In addition, the Combined Sources Plan (DMH Form 9013) will be used to summarize all supports received by the individual. This document will be submitted to Central Office along with the Residential Budget Plan.
(See Appendix B.)

If the individual is participating in the Waiver, the Room and Board costs will be placed on the DMH 57. However, the Residential Habilitation costs will be shown on the State of Missouri - Department of Mental Health, Division of MR/DD, Individual Plan of Care, Authorization Request (DMH 8806). In addition to serving as an authorization request, the Individual Plan of Care is also used to summarize all supports received by the individual. Therefore, the Combined Sources Plan will not be completed for persons participating in the Waiver.
Leave Days and Hospitalization

Due to the fact that Individualized Supported Living occurs in the person's own home, the concept of 'leave days' from a 'placement facility' does not apply. Therefore, we will not utilize 'leave days' in Individualized Supported Living.

However, if the individual is participating in the Medicaid Home and Community Based Waiver, 'hospitalization days' must be considered. This is essential as HCFA will not allow payment from two separate sources for the same time period. For example, if the individual is hospitalized in a Medicaid bed, Federal Financial Participation cannot be obtained for waivered services during the same time period. Room and Board costs can continue during that period. Extended hospitalizations beyond 30 days must be negotiated with the Regional Center to determine whether Room and Board funding will continue. Residential Habilitation costs would be reimbursed as per guidelines on "Absences from Community Placement Facilities" contained in the Medicaid Home and Community Based Waiver Training Manual.

Fiscal Tracking

It was recommended by the Individualized Supported Living Task Force that Supported Living funds be established and tracked separately. Ideally, funding should not be identified as either Placement or POS but rather should encompass the residential and other Purchase of Service costs unique to the individual within one allocation. This may necessitate minor adjustments of this appropriated amount during the fiscal year. For example, as individuals leave existing placement options, there may be occasions when funding might be redirected to the Supported Living allocation.

Fiscal tracking will be extremely important in that costs within any given provider agency will fluctuate more than they had under a facility based model. As such, tracking will permit awareness of these fluctuations and result in the ability to make needed adjustments.

While budget plans are approved at the regional center level, if they are within stated limitations, all budget plans must be submitted to Central Office. Central Office will track the overall cost effectiveness of the Individualized Supported Living model.
CHAPTER VII

QUALITY ASSURANCE
CHAPTER VII
QUALITY ASSURANCE

Due to the fact that Individualized Support Living is, by its nature, flexible and individually prescriptive, quality assurance becomes an important issue. Each individual's support plan may involve assistance from diverse sources. Many of these supports will be non-traditional. Therefore, the coordination among supports and the assurance that needs are being met in a manner that enhances quality of life is critical. To ignore the quality assurance component could place the person in jeopardy and the provider and state in a position of potential liability.

On the other hand, the apartment or house is the individual's own home in a way that is not true of most other "placements". Therefore, traditional licensure options as we know them in Missouri are inappropriate.

Individualized Supported Living requires a very different approach than that followed in the regular Community Placement Program. Because of its very nature and the philosophy on which it is based, different emphases are required. Rather than placing primary emphasis on site related rules or regulations, concern is shifted to programmatic issues.

A viable quality assurance approach is essential to Individualized Supported Living. This approach must respect the dignity of the individual while assuring them quality service delivery. The following pages reflect an alternative approach to quality assurance designed specifically for Individualized Supported Living.

INDIVIDUALIZED SUPPORTED LIVING ACCREDITATION

Licensure is inappropriate for an ISL model. Accreditation is preferable as it emphasizes programmatic issues. All ISL lead agencies must be nationally accredited through CARF or ACDD. Agencies which are not accredited must attain national accreditation or state certification within a 2 year time period from the start of ISL service provision. Any exceptions to this process require the prior written approval of the Director, Division of Mental Retardation and Developmental Disabilities. No exceptions are allowed within the Medicaid Home and Community Based Waiver. If the Regional Center or Habilitation Center serves as the lead provider/resource, the Center is exempt from the accreditation requirement.
In the interim until the provider is accredited, agencies must be licensed in accordance with all Missouri State licensure standards for Family Living Arrangements. When ISL licensure becomes available, this will be used in lieu of FLA licensure during the two year time period before the agency becomes accredited or certified.

PROGRAM EVALUATION

The provider or the state agency may, in addition, choose to undertake other program evaluation options. Such evaluations might be geared to address quality of life issues, measure specific outcomes, determine whether the process was responsive to individual need, etc.

The provider may choose to pose the following evaluative questions geared to determine whether the program, as implemented, is consistent with the conceptual foundations:

1. Did the individual choose the person(s) with whom they are living?

2. Did the individual choose the site where they live?

3. Is the residence where the individual(s) live of the same size as other homes in the community?

4. Does the residence look and feel like a home not a facility? (Is it a home rather than home-like?)

5. Is the decision of who will own the home made after knowing who will live there?

6. Do individuals move because they choose to do so or because of skill acquisition?

7. Is the home of such a size that socializing, scheduling, programming, and daily routine are individualized?

8. Is the daily schedule flexible enough to allow for an individual to choose to not participate in a group activity?

9. Are leisure activities varied and individualized?

10. Do leisure activities include involvement with non-disabled peers?

11. Are there a variety of leisure activities accessible on a regular basis?
12. Is the individual Habilitation Plan largely driven by the personal preferences, interests, and priorities set by the individual with disabilities?

13. Does the IHP reflect the teaching of skills in the setting where they are used, occurring at the time of day activities normally occur, and taught in a functional manner?

14. Are individuals with disabilities respected for saying "No" to activities or programs and not forced to participate?

15. Are individuals with disabilities encouraged to become active members of their communities, including assuming positions of leadership?

The Regional Center may choose to undertake a quality assurance review. Quality assurance materials which are appropriate to ISL include IHP Checklists E & F, Behavior Management Checklists M & N, and the Community Integration and Social Relationships Checklist R. All these checklists are available through the Quality Assurance staff at the Regional Centers. Other Department of Mental Health quality assurance checklists are inappropriate for use in ISL.

Department of Mental Health, Division of Mental Retardation and Developmental Disabilities may choose to evaluate statewide outcomes. For example, DMH-DMRDD will evaluate cost effectiveness of this model.

CONSUMER REVIEW

Any evaluation of a social service must include an assessment of consumer satisfaction. Assessment can also be done to determine if a program is being implemented in a way that meets the needs and wishes of those participating. Quality of life measures like that developed by Schalock, Keith, Hoffman, and Karan (1989) might be of assistance in this endeavor. The "1990 Quality of Life Questionnaire" developed by Schalock, Keith, & Hoffman is available through the Division of Mental Retardation and Developmental Disabilities.

APPENDIX A

CLINICAL CRITERIA FOR RESIDENTIAL SERVICES

AND

COMPREHENSIVE SERVICES MODEL
OFFICIAL DIRECTIVE

Chapter: Program Planning and Records

Section: Admission Procedures

Number of Pages: 2

Policy Number: O.D. 4.354

Effective Date: Dec. 13, 1987

Authority: 633.110-120 RSMo.

Subject: Clinical Criteria for Residential Services

Signature: [Signature]

Gary V. Sluyter, Ph.D., M.P.H., Director

Application: Applies to DMR-DD regional centers

Purpose: Prescribes the clinical indicators for prioritizing admissions to the division's residential services program, pending promulgation of a Department Operating Regulation of similar content.

1. A client who has requested admission to community or state residential services may be placed out of their own home environment by the Division of Mental Retardation and Developmental Disabilities only under the following circumstances:

   A. Protective services are required to guarantee the health, safety or mental well-being of the client because:

      1) the individual is without housing and/or necessary care and supervision as a result of the death, extreme mental/physical fragility related to age, emotional instability of the family system or serious, permanent illness of the primary caretaker; and/or

      2) imminent danger exists of the client injuring himself or others; and/or

      3) abuse or neglect of the client within the home environment has been documented/substantiated/clinically judged as "strong reason to suspect occurrence," leaving the client at risk; and/or

      4) family support services provided in the home environment cannot meet the client's medical health treatment needs, placing the client at risk;

   or,

   3. Residential services are needed to meet the client's specialized needs in growth and development; and,
C. All non-residential service options, identified as appropriate by the
LKP team, have been exhausted and determined by the case manager,
case management supervisor and LKP team to have been unsuccessful or
grossly inadequate to meet the protective or habilitative needs
of the client. Dates and results of authorized service provision
shall be documented.

2. Case Managers shall complete a referral for residential placement (DMH Form
8753) and transmit that document to the Regional Center Placement Committee
for consideration.

A. The Regional Center Placement Committee membership shall include the
Assistant Center Director (Habilitation), Case Management Supervisors
for all Case Management teams, and other QMRP staff as designated by
the Regional Center Director.

B. The Placement Committee shall prioritize clients for admission (if to
a state habilitation center) or referral to community residential
services, based on the criteria listed in section 1, paragraphs A
(1)-(4) and B. The committee shall document disposition of the initial
referral on the DMH Form 8753, which shall be reviewed monthly by the
Case Manager and Placement Committee chairperson, for updating, until
admission to residential services is effected.

C. All admissions and final referrals must be approved by the Regional
Center Director.

D. Clients not accepted by the identified provider for admission to
residential services will be placed on a prioritized referral list for
matching with vacancies as they occur.
DIVISION OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

COMPREHENSIVE SERVICES MODEL

I. PURPOSE

The Division of Mental Retardation and Developmental Disabilities is charged with the responsibility for planning, providing, and overseeing services for Missouri's mentally retarded and developmentally disabled citizens. In accordance with Chapter 635, RSMo., the Division provides or secures services within the least restrictive environment and consistent with individualized habilitation plans.

The Comprehensive Services Model is a philosophical framework, designed to provide a sense of direction for the prioritization of the array of services which may be available through the regional centers. The model defines core and prescriptive services for the Division, and is established to achieve the following goals:

1. To define the basic, mandatory services available for all eligible individuals with mental retardation and developmental disabilities;

2. To describe an array of prescriptive services which may be provided, based on individual need; and

3. To provide a broad sense of prioritization within the prescriptive array.

II. SERVICES MODEL

The model displayed in the attachment is conceptualized as a two-level system:

Level I defines core or mandatory services which must be provided or procured for all persons entering the service delivery system. This level defines basic assessment and case management services which enable individuals to enter the system and which assist them in accessing needed generic and specialized services.

Level II describes an entire array of service options which may be provided to an individual. The determination of which services actually are provided is guided by an examination of clinical need by the interdisciplinary team which, in turn, incorporates them into the individualized habilitation plan (IHP) as a set of service goals.
This model is designed to provide regional centers with a broad sense of prioritization for the implementation of service goals. For example, assume that a person's IHP prescribes the following individualized goals:

1. Residential care in a group home,
2. In-home respite care for the family,
3. Speech therapy, and
4. Recreation services.

The interdisciplinary team and case management staff review these goals in light of the three clusters of prescriptive services:

1. Family Support Services,
2. Habilitation Services, and

According to the Comprehensive Services Model, staff will prioritize those Family Support Services (respite care), designed to help the individual remain in his/her own environment. Second priority services, then, are those contained in the Habilitation cluster (speech therapy and recreation), followed by those in the Residential cluster (group home).

While the three clusters of services (Family Support, Habilitation, and Residential) are listed in a descending order of priority, the services included in each are not. For example, "respite care," under Family Support, is not indicated as a higher priority than "behavior management consultation," even though it is listed first in the cluster.

This model is intended to help guide resource allocation decisions within the parameters of individual needs. For example, a service from the Family Support cluster would generally take priority over both day and residential services, but on an individual basis. Prioritization of a residential placement becomes possible once other options have been considered and judged to be not as appropriate.

While this model guides resource allocation for individuals, it does not speak to the setting of funding priorities on a regional basis for all clients. In other words, allocating services for Habilitation or Residential services would be appropriate for a given client, even though funding for all required Family Support services may not be available within the region.
III. INTERAGENCY COOPERATION

The Comprehensive Services Model is designed to be implemented in concert with other agencies and organizations in the state with interlocking missions for serving mentally retarded/developmentally disabled persons. For example, the Department of Health's role in primary prevention would be supplemented by supportive or follow-up counseling at both Level I and Level II. Secondary prevention efforts under the Family Support cluster (infant stimulation and early childhood training) must be closely coordinated with the Department of Elementary and Secondary Education as that agency phases in similar programs within the public education system. Finally, supportive employment services are provided as extended care and may begin only after the Division of Vocational Rehabilitation's support has ended.

IV. AUTHORITY

The Comprehensive Services Model was formally adopted by the Mental Health Commission in regular session on November 12, 1987, and became effective as of that date.
### Level I - Core Services

**ASSESSMENT**
- Initial Eligibility Determination
- Annual and Follow-up Evaluations

**CASE MANAGEMENT**
- Intake
- Service Planning (IIP Development)
- Service Coordination & Referral
- Monitoring
- Supportive Counseling
- Crisis Intervention
- Advocacy

### Level II - Prescriptive Services

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<thead>
<tr>
<th></th>
<th>FAMILY SUPPORT</th>
<th>HABILITATION</th>
<th>RESIDENTIAL</th>
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<tbody>
<tr>
<td>1</td>
<td>Respite Care</td>
<td>Training Programs</td>
<td>Foster Care</td>
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<td></td>
<td>Early Intervention</td>
<td>• Activities of Daily Living</td>
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<td></td>
<td>• Parent Instruction</td>
<td>• Home Management</td>
<td>B. Semi-Independent Living Arrangements</td>
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<td>• Infant Stimulation</td>
<td>• Community Integration</td>
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<td>• Early Childhood Training</td>
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<td>Individual/Family Counseling</td>
<td>Therapies</td>
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<td></td>
<td>B. Emergency Residential Care</td>
<td>• Occupational</td>
<td>C. Community Group Living Arrangements</td>
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<td>D. Behavior Management Consultation</td>
<td>• Physical</td>
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<td></td>
<td>F. Attendant/Sitter Services</td>
<td>• Behavioral</td>
<td>D. Habilitation Centers</td>
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<td>G. Home Health Care Service</td>
<td>• Speech</td>
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**TRANSPORTATION**
APPENDIX B

ISL RESIDENTIAL BUDGET PLAN & DIRECTIONS
&
INDIVIDUALIZED SUPPORTED LIVING
COMBINED SOURCES SUPPORT PLAN
INDIVIDUALIZED SUPPORTED LIVING

RESIDENTIAL BUDGET PLAN

DEMOGRAPHIC INFORMATION

Name: Give the name of the individual for whom the budget plan is being prepared. Last Name, First Name, Middle Initial

Address: Give the Street Address, City, State, and Zip Code of the place the individual is or will be living.

Total # of People Sharing Household: Indicate the number of individuals living in the household who receive Department of Mental Health funding. This does not include staff or other non-disabled individuals living in the home. If there are any non-DMH, non-provider staff, indicate separately in parenthesis on this line.

Former Placement: Indicate the former DMH or non-DMH placement of this individual prior to the initiation of this contract. Give the name of the DMH provider.

Alternative Placement: Indicate the name of the home/facility which would be considered as an alternative if ISL were not an option.

Accredited/Lead Agency: Indicate the name of the provider/agency which will be providing Residential Habilitation services. (See Section VII, Page 1 regarding exceptions to accreditation).

Waiver Recipient: Check the appropriate responses (Yes/No) to indicate whether this individual will participate in the Medicaid Home and Community Based Waiver.

ID #: Indicate the complete DMH client identification number. This number should be entered and verified on census.

Medicaid #: Indicate completely and accurately the Medicaid Number. This number should be entered and verified on census.
Authorization Period: This refers to the length of time the rate will be effective. Time frames will coincide with the IHP. Initial Residential Budget Plans will be for three months. Thereafter, budget plans may be approved for a minimum of one month or may extend through the duration of the IHP. For fiscal tracking purposes, the Regional Center will plan for funds through fiscal year periods.

IHP Dates: This should reflect the effective dates of the IHP. The IHP/program year can never be more than 365 days.

BUDGET PLAN

The budget plan section of this document is divided in half. The left side of the page deals with Room and Board costs and the right side of the page deals with program costs (Residential Habilitation). If more than one individual is living in any given ISLA setting, applicable costs should be divided by the number of individuals. Total Room and Board costs to the state may not exceed $15 per day per person. Rates are derived separately for each service (Room & Board and Residential Habilitation). This separation is necessary for the following reasons:

1. Room and Board costs are ineligible for federal financial participation under the Medicaid Home and Community Based Waiver.

2. Residential Habilitation costs are covered by Department of Mental Health whereas the Room and Board costs can be covered by a variety of resources. Examples might include food stamps and rent and utilities subsidies.

Room & Board Costs - This section is divided into Board costs and Room costs. Monthly amounts should be used in deriving rates.

Both the Board and the Room sections contain three columns. These include Total Cost, Other (source), and Remaining Cost. These columns are defined as follows:

Total Cost: Amounts entered in this column represent the complete cost of the specific line item. For example, the total rent for an apartment for a specific individual is $300.00 per month.
Other (Source): Amounts entered in this column represent resources accessed which are not monthly financial benefits the individual receives. List only those resources which will not later be deducted from the DMH 57. Benefits covered on the DMH 57 include SSI, SSA, Railroad Retirement, and VA benefits. For a complete benefit listing covered on the DMH 57, see the Community Placement Financial System User's Guide. This column must include resources such as HUD subsidies, food stamps, utility subsidies, etc.

Remaining Costs: Deduct amounts listed in the "Other/Source" column from those listed in the "Total Cost" column. Enter the remainder here.

Board Costs: Examples of how to complete the budget plan for each line item are as follows:

Food: Enter monthly food costs under the various headings. Data suggests that it is unlikely that the total food costs for one person for one month would be less than $136 or more than $180 including the value of food stamps.

Transportation: Examples include bus passes, cab fare, etc. for transportation to the grocery store, bank, and other community services. Transportation is limited to $40.00 a month. More specialized transportation needs can be addressed through the POS system or as a part of Residential Habilitation.

Household Supplies - Examples include paper towels, toilet paper, laundry detergent, dish soap, consumable cleaning supplies, etc. As a guideline, costs should generally be at or below $25.00 a month.

Other - Enter amounts for any other Board costs or any specific costs related to independent living. Items must be delineated separately.

SUB-TOTAL - Enter the total of the "Remaining Costs" column only.
Room Costs: Use the same procedures as for Board Costs.

**Monthly** amounts must be used in figuring rates. Rent, utilities, and telephone must be completed. The "Other" section must separately list other room related costs. Examples might include renter's insurance and service agreements on household appliances.

If other sources have been exhausted, the depreciation or rental of furnishings may be used. A limit of $5,000 depreciated over five years or $83 a month may be used for furnishings.

**SUB-TOTAL** - Total the "Remaining Costs" column only.

**Total Monthly Room & Board:** Add the sub-total of the "Remaining Costs" for both the Room and Board sections.

**Total Daily Room & Board:** Multiply the Total Monthly Room & Board Costs by 12 and then divide by 365. If Department of Mental Health funds are required to supplement Room and Board, DMH will not recognize costs exceeding $15.00 per person per day without the prior written approval of the Director of the Division of Mental Retardation and Developmental Disabilities.

**RESIDENTIAL HABILITATION**

Residential Habilitation involves the provision of ongoing training or active habilitation. Individuals are actively involved in IHP driven programs which maximize their potential. Individualized supported living requires that functional skill development take place in naturally occurring settings in the community. All costs are based on **monthly** estimates. Staff positions are described below. Any specific individual may not require all three levels of staffing. Participation in the Medicaid Home and Community Based Waiver does require oversight of direct service staff by a QMRF. The number of hours of service required during a month should be directly tied to the individual's IHP.

**Community Specialist:** This staff person is engaged in supervision of Community Integration Skills trainers and may also directly provide IHP related training to individuals with very high intensity needs. The Community Specialist provides training, quality assurance monitoring, and supervision to other involved staff. In small agencies or in situations with individuals requiring less intense intervention, this position may not be required.
This position requires a QMRP with a Masters Degree or a Bachelors Degree and three years of experience in the field of MR/DD. Education and experience requirements for a QMRP are contained in Appendix C.

This line is completed in two stages. The first blank requires that you determine the number of hours per month. This will be determined by the IHF, size of the agency, and whether or not the individual demonstrates high intensity needs.

The second blank is the product of multiplying the number of hours times the allowable rate. The rate is based on commensurate state salaries plus 33% fringe benefits. The rate is $15.31 per hour. The 33% fringe benefit figure covers retirement, health and medical insurance, life insurance, disability and accident insurance, FICA, Workman's Compensation, unemployment insurance, vacation, sick leave, education leave, holidays, and other incentives provided directly to the employee.

**Community Integration Skills Trainer:** This staff person serves as a supervisor of direct service staff. In small agencies or in situations with individuals requiring less intensive intervention the Community Integration Skills trainers may be the primary manager and may not be supervised by a Community Specialist. The Community Integration Skills trainer is heavily involved in the IHF process. This position requires writing training programs, training direct care staff, monitoring implementation of programs, establishing data collection systems, and writing data based monthly reviews. In small agencies this may be a part time position.

This position requires a QMRP with a Bachelors Degree in a discipline which will meet these qualifications (see Appendix C) and one year of experience in the field of MR/DD.

The first blank requires that you determine the number of hours per month. This will be heavily IHF driven and will, to some extent, be dependent upon the size of the agency.

The second blank is the product of multiplying the number of hours times the allowable rate. The rate is based on commensurate state salaries plus 33% fringe benefits. The allowable rate is $13.04 per hour. The 33% fringe benefit figure covers retirement, health and medical insurance, life insurance, disability and accident insurance, FICA, Workman's Compensation, unemployment insurance, vacation, sick leave, education leave, holidays, and other incentives provided directly to the employee.

**Direct Service:** This staff person provides direct care and training. Direct service staff may, in some cases, be responsible for routine care and oversight. Direct care staff shall always be responsible for implementation of training programs as assigned by Community Integration Skills trainers.
This position does not require a college degree. Graduation from High School or completion of GED are necessary qualifications.

The first blank requires that the number of hours per month be determined. This will be completely determined through the IHP.

The second blank is the product of multiplying the number of hours per month times the allowable rate. The rate is based on commensurate state salaries plus 33% fringe benefits. The allowable rate is $9.73 per hour. The 33% fringe benefit figure covers retirement, health and medical insurance, life insurance, disability and accident insurance, FICA, Workman’s Compensation, unemployment insurance, vacation, sick leave, education leave, holidays, and other incentives provided directly to the employee.

Staff Mileage: Staff mileage is figured to and from the homes of Individualized Supported Living participants. The number of miles per month is listed in the first blank. The second blank is completed by multiplying the number of miles times the Department of Mental Health reimbursement rate (20.5 cents per mile).

Other: On the lines below this heading, list any other habilitation related expenses. This could include a wide variety of options. Because of their specific disabilities, some individuals may require security devices or medical alert systems. Consultants such as Occupational Therapists, Speech Therapists, Physical Therapists, or Behavioral Therapists may be needed to provide staff training or monitoring for the provider agency in general. (Note: Individual therapy or consultation related to a specific individual should continue to be billed separately).

Staff training may be included within this category if it is off site. Therapists may be used for staff training purposes if the training is general and not tied to any one specific individual. Training provided by a therapist which is person specific must be authorized separately as a discrete service through the IPC process or appropriate system under regular POS. Training costs may not exceed $50.00 an hour without justification and approval by the Regional Center.

Program equipment and supplies may be included in this category. An itemized listing of equipment and supplies with item specific costs must be submitted before approval by the Regional Center.

The agency may subcontract with neighbors or others in the community to fulfill specific functions. However, if the individual is participating in the Waiver, the agency would need to hire any such indigenous workers.
While the items in this category may be diverse, they should all be directly IHP driven. The Regional Center may request itemized documentation on any cost appearing in this section.

Case Coordination: A flat $200 case coordination fee is included in all Individualized Supported Living rates. The agency assumes the responsibility for providing a "safety net" for the individual. As the lead provider's provision of direct service intervention decreases and generic services and other informal supports increase, the case coordination function becomes even more important. They maintain a phone number which will be answered 24 hours and will assure a regular point of contact for individuals. They coordinate all community supports and assure that others involved have delivered services as planned. They maintain contact with the individual's family and assist the individual in making any desired moves or changes. The lead provider, as a part of case coordination, monitors overall delivery of supports, seeks additional avenues of support as needed or desired, and acts as the individual's advocate.

The flat fee is based on a QMRP salary plus fringe benefits at a one to sixteen ratio. Pagers were also figured in deriving this cost.

In order to continue inclusion of the case coordination fee, the lead agency shall maintain direct service contact a minimum of three hours per individual per month.

**SUB-TOTAL:** Residential Habilitation costs from all of the lines above are subtotalled.

Monthly Administrative Reimbursement: The subtotal column is multiplied by the percentage of administrative costs. This percentage will not exceed 15%. No amounts reflected earlier in the budget plan may be included in the administrative costs.

The Regional Center will review the agency's most recent audit in this area. In the case of new agencies, the Regional Center will review a proposed, prospective administrative budget. If this review justifies less than 15%, the actual or proposed amount (which is less than 15%) must be used. The administrative reimbursement may not include any costs already presented in the preceding portions of the ISL budget. For example, care, coordination, fringe benefits, training, and travel related to specific individuals could not be included.

**Total Monthly Residential Habilitation:** Add the Monthly Administrative Reimbursement amount to the subtotal.

**Daily Residential Habilitation Rate:** Multiply the Monthly Residential Habilitation amount by 12. Then divide this figure by 365.
APPROVAL: The "Approval" section of the Individualized Supported Living Residential Budget Plan requires signatures and dates from the Director of the Individualized Supported Living provider agency and the Regional Center Director. The approval of the Director of the Division of Mental Retardation and Developmental Disabilities is only obtained when total Room and Board and Residential Habilitation costs in FY '90 exceed $85 per day and in FY '91 exceed $90 per day. However, all ISL Residential Budget Plans must be submitted to the Medicaid Waiver and Community Residential Development Coordinator for fiscal tracking purposes regardless of cost.
MISSOURI DEPARTMENT OF MENTAL HEALTH
Division of Mental Retardation and Developmental Disabilities

INDIVIDUALIZED SUPPORTED LIVING
RESIDENTIAL BUDGET PLAN

Name ________________________________ ID# ________________________________
Address ________________________________ Medicaid # ________________________________

Total # of People Sharing Household __________________________
Former Place. ____________________________
Alternative Place ____________________________
Accredited Lead Agency ____________________________
Waiver Recipient: Yes ________ No ________

Authorization Period
From ___________ To ___________

IHP Dates
From ___________ To ___________

BUDGET PLAN

ROOM & BOARD

<table>
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<th>Board</th>
<th>Total Cost</th>
<th>Other (Source</th>
<th>Remain. Cost</th>
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<td>Food</td>
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<tr>
<td>Trans.</td>
<td>$________</td>
<td>$ (____)</td>
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<tr>
<td>House.</td>
<td>$________</td>
<td>$ (____)</td>
<td>$________</td>
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<tr>
<td>Supp.</td>
<td>$________</td>
<td>$ (____)</td>
<td>$________</td>
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<tr>
<td>Other:</td>
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<td>$ (____)</td>
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SUB-TOTAL

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<td>Util.</td>
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<td>Phone</td>
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Community Specialist $15.31 hr. X ______ $_______
Community Integration Skills Trainer $13.04 hr. X ______ $_______
Direct Care $9.73 hr. X ______ $_______
Staff Mileage 20.5 cents X ______ miles $_______
## INDIVIDUALIZED SUPPORTED LIVING
### COMBINED SOURCES SUPPORT PLAN
#### (NON-WAIVER)

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<th>COST</th>
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<td>Room &amp; Board</td>
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<td>Residential Hab.</td>
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<tr>
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GRAND TOTAL_______________  DMH TOTAL_______________
APPENDIX C

QUALIFIED MENTAL RETARDATION PROFESSIONAL DEFINITION
July 1, 1990

Proposed Definition: Complies with Federal Regulation

Qualified Mental Retardation Professional

The following represents the minimum requirements individuals to be considered to be considered qualified mental retardation professionals.

1. **Psychologist:** A person with at least a master's degree in psychology from an accredited school and with at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

2. **Physician:** A doctor of medicine or osteopathy who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

3. **Social Worker:** A person who holds a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or a person who holds a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body. The social worker must also have at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

4. **Occupational Therapist:** A person eligible for certification by the American Occupational Therapy Association or another comparable body and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

5. **Physical Therapist:** A person who is eligible for certification by the American Physical Therapy Association or another comparable body and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

6. **Speech Pathologist or Audiologist:** A person who is eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the Speech-Language-Hearing Association or another comparable body; or a person who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification. A speech pathologist or audiologist must also have at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

7. **Registered Nurse:** A person who is a registered nurse and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.

8. **Professional Recreation Staff Member:** A person who has a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education and who has at least one year of experience in working directly with persons with mental retardation or other developmental disability.

9. **Human Services Professional:** A person who has at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counselling and psychology) and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.
APPENDIX D

REFERENCES
REFERENCES


Bogdan, R. It's a Nice Place to Live: Professional Foster Homes and Supervised Apartments in Washington County, Vermont. Syracuse, NY: Center on Human Policy.


New Housing Options for People with Mental Retardation and Related Conditions: A Guidebook. Minneapolis: Minnesota Department of Human Services and ARC of Minnesota.


