

**THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
YOUTH EMPOWERMENT SERVICES (YES) WAIVER
PROGRAM FAMILY-ASSISTED SERVICES**

- Complete, date and sign the enclosed YES Waiver Application
- Attach a copy of proof of Professional Liability Insurance
- Attach a list of all of your facility sites with addresses
- Completed Service Description Questionnaire

Send all requested materials to:

The HARRIS CENTER for Mental Health and IDD

Attn: Stella Olise, Program Director

YES Waiver Program

6032 Airline Drive

Houston, Texas 77076

Office: 713 – 970 – 4385

Fax: 713 – 970 – 4995

Email: Stella.Olise@theharriscenter.org or Dulce.Hernandez@theharriscenter.org

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD YES WAIVER PROGRAM – FAMILY-ASSISTED SERVICES

APPLICATION

A. General Information:

Facility Legal Name			Does the facility have another Name? If yes, please list name:	
Preferred Mailing Address Line 1			Preferred Mailing Address Line 2	
City	State	Zip	County	Contact Person
Physical Address			Physical City, State & Zip	
Telephone	Email Address		Fax	
<input type="checkbox"/> Apartment Complex <input type="checkbox"/> Residential Facility Please check which is the most appropriate description:		<input type="checkbox"/> SRO <input type="checkbox"/> Other		Indicate who is your corporate owner (if applicable):
Is this facility handicapped accessible? Yes <input type="checkbox"/> No <input type="checkbox"/>			Is this facility accessible to public transportation? Yes <input type="checkbox"/> No <input type="checkbox"/>	

B. DEMOGRAPHIC DATA: The following information is requested for demographic purposes only. This data will not be part of the credentialing process, but may be used to supply aggregate data to the state government as part of a state funded contract process.

1. Could your business be classified as a business owned by women, as defined by the Department of Minority Enterprises?
 Yes No

Women Owned Business is defined as a business enterprise of which women own at least 50%or, in the case of a publicly owned business, where women own at least 51% of stock.

2. Could your business be classified as a minority owned business, as defined by the Department of Minority Enterprises?
 Yes No

Minority Owned Business is defined as a business enterprise that is owned and controlled by one or more socially and/or economically disadvantaged persons. Such disadvantages may arise from cultural, racial, chronic economic circumstances or background, or other similar cause.

3. Could your business be classified as a minority owned business, as defined by the Department of Minority Enterprises?
 Yes No

Veteran Owned Business is defined as a business enterprise that is at least 51% owned and controlled by one or more service-disabled veterans. Have one or more service-disabled veterans manage day-to-day operations and also make long-term decisions.

4. If you answered yes to questions 1, 2 and 3 about minority owned businesses, which of the following categories would it fall under:

<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American or Alaskan Native	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> Black (African, Jamaican, West Indian descent)	<input type="checkbox"/> Hispanic (Mexican, Puerto Rican, South American)	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Veteran		

C. PAYEE INFORMATION

Make checks payable to (must match tax ID owner name on file with IRS for the TIN listed below)		Type of Corporation	
Billing Address Line 1		Billing Address Line 2	
City		State	Zip
Your Medicare/UPIN Number	Your Medicaid Number	Tax Identification Number (TIN)	

ATTESTATION

- 1. Insurance Coverage:** Have you or any of your staff had their Professional Liability insurance coverage denied, canceled, or non-renewed or initially refused upon application? Yes N/A No
- 2. License:** Have you or any of your employees had their professional licenses in any state revoked, suspended, placed on probation, given conditional status or otherwise limited? Yes N/A No

 - a. Have you or anyone on your staff ever voluntarily surrendered their professional license in any state? Yes N/A No
 - b. Do you or any members of your staff have formal charges pending against them at this time? Yes N/A No
- 3. Criminal Offenses:** Have you or anyone on your staff ever been convicted of a felony involving moral or ethical turpitude or substance use or sale? Yes N/A No
- 4. Board Discipline:** Have you or anyone on your staff ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county; state or national professional society, etc.?). Yes N/A No
- 5. Malpractice Action:** Has any malpractice action been brought or settled against you or anyone on your staff within the last 5 years, or have there been any unfavorable judgement(s) against you or any members of your staff in any malpractice actions? Yes N/A No

 - a. To your knowledge, are any malpractice actions currently pending against you or any members of your staff? Yes N/A No
- 6. Neglect and Abuse:** Have you or anyone on your staff ever been sued for abuse or neglect? Yes N/A No

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD

Open Enrollment Application Process

To Provide Family-Assisted Services

The HARRIS CENTER for Mental Health and IDD (“The HARRIS CENTER”), through its YES Waiver Program, is offering to contract with Providers that will provide Family Assisted Services support to the Waiver participant(s) and to model appropriate behaviors for individuals identified by the YES Waiver Program.

OVERVIEW OF PROGRAM:

The YES (Youth Empowerment Services) Waiver program is a Medicaid Home and Community-Based Services Waiver that allows for more flexibility in the funding of intensive community-based services to assist children and adolescents with severe emotional disturbances to live in the community with their families.

Waiver services are provided in combination with services available through the Medicaid State Plan, other federal, state and local programs the individual may qualify for, and the natural supports that families and communities provide.

Family-Assisted Services Include:

- Family Supports
- Supported Employment
- Respite (In-Home)
- Out of Home (Camp)
- Out of Home (DFPS)
- Supportive Family-Based Alternatives
- Non-Medical Transportation

Goals

1. Reducing out of home placement and inpatient psychiatric treatment
2. Providing a more complete continuum of community-based services and supports
3. Ensuring families have access to parent partners and other flexible non-traditional support services as identified in a family-centered planning process
4. Preventing entry into the foster care system and relinquishment of parental custody: and
5. Improving the clinical and functional outcomes of children and adolescents

VENDOR’S ROLE:

To provide services that will assist in reducing the amount of time Waiver participant(s) are out of their home and community because of mental health needs; expand the available mental health services and supports; and assist in improving the lives of children and youth.

VENDOR CRITERIA: Each Applicant must provide the following:

- Complete, date and sign the Application.
- Attach Texas Standard Application for Licensed individuals -LCSW, LPCs, LMFTs, LVN and Psychologists etc. (as applicable)
- Accurately complete, date and sign the W-9 Form for each Tax Identification Number (TIN)
- Attach a copy of your Licensure (if applicable)

- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Registered Nurse
- Marriage and Family Therapist
- Licensed Vocational Nurse
- Physical Therapist
- Occupational Therapist
- Licensed Dietitian
- Certified by the Art Therapy Credentials Board (AT-BC)
- Equine Assisted Growth and Learning Association
- Certified by the National Counsel for Therapy and Recreation Certification (CTRS)
- Certified as a Texas Certified Therapeutic (TRS/TXC)
- Professional Association of Therapeutic Horsemanship (PATH) International
- Certified by the Certification Board for Music Therapists (MT-BC)
- Attach a copy of your Certification (if applicable)
- Attach a copy of DFPS Respite Certification
- Please include any Medicaid/Medicare Licenses and all other applicable licenses held by the facility that relate to the contracted services
- Attach a copy of your Program Description
- Attach a copy of your Malpractice Insurance Face Sheet with the limits of liability
- Attach a list of all your facility site(s) with addresses.
- Attach a list of other employees with Professional Credentials
- Attach a copy of Clinical Descriptions of all programs
- Attach Program brochures (if available)

The HARRIS CENTER's Role:

The HARRIS CENTER will assign staff to secure services. The Agency, through its designated staff, is responsible to receive, review and approve all applications.

All applications will be reviewed upon receipt. Open Enrollment Applications will remain open for two years pursuant to the Open Enrollment statutory requirements set forth at 25 Tex. Admin. Code §412.60.

SERVICE DESCRIPTION FORM

Contract Provider Name:

Service To Be Provided:

- Family Supports**
- Supported Employment**
- Respite (In-Home)**
- Out of Home (Camp)**
- Out of Home (DFPS)**
- Supportive Family-Based Alternatives**
- Non-Medical Transportation**

Description of Current Services:

- a. What is your philosophy of service delivery?

- b. How many people are currently receiving this service through your program?

- c. How many people can your program accommodate?

- d. What in general, are the ages, intellectual/functional abilities, and diagnoses of your current population?

- e. What are the characteristics that would result in a person being deemed inappropriate to be served in your program?

- f. What information is required for a patient being referred to your program?

- g. Additional information about your program:

Form Completed by (Signature):

Print Name/ Title:

Date:

PARTICIPATION STATEMENT

Vendor warrants and assures The HARRIS CENTER for Mental Health and IDD that:

1. Vendor is financially solvent, able to pay all debts as they mature and possess sufficient working capital to complete the work and perform the obligations herein;
2. Vendor is not currently held in abeyance or barred from the award of a federal or state contract;
3. Vendor is currently in good standing for state tax, pursuant to Texas Business Corporation Act, Texas Civil Statutes, Article 2.45; and
4. Vendor agrees to provide the specified services at the rate of payment specified herein.

I FULLY UNDERSTAND THAT IF ANY MATTER STATED IN THIS APPLICATION IS OR BECOMES FALSE, THE HARRIS CENTER WILL BE ENTITLED TO TERMINATE MY PROVIDER AGREEMENT FOR BREACH. FURTHER THAT ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS WARRANTED TO BE TRUE, CORRECT AND COMPLETE.

Name (Please Print)

Date

**RETURN COMPLETED APPLICATION TO:
(MUST BE ORIGINAL)**

The HARRIS CENTER for Mental Health and IDD
YES Waiver Program
Stella Olise, Practice Manager
6032 Airline Drive
Houston, Texas 77076
Office: (713) 970 – 4385
Fax: (713) 970 – 4995
Email: Stella.Olise@TheHarrisCenter.org and/or
Dulce.Hernandez@theharriscenter.org

PUBLIC NOTICE

The HARRIS CENTER for Mental Health and IDD (“The HARRIS CENTER”) (formerly known as **MHMRA of Harris County**) is the Texas Department of State Health Services (“DSHS”) designated Local Mental Health Authority (LMHA) established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of community based mental health services for the residents of Harris County, Texas. The HARRIS CENTER is requesting providers to apply to our Open Enrollment process to expand our network of service providers for Children Mental Health Clients who are assessed into the Level of Service YES Waiver program. **These services include Family-Assisted services.** The provider enrollment period will be continuous or until the Local MHA has received enough applications to meet the percentage of service capacity stated in the Request for Application (RFA).

YES Waiver services for the geographic area of Harris County include:

Specialized Therapies focused on the reduction or elimination of a client's symptoms of mental illness and increasing the individual's ability to perform activities of daily living. Counseling shall be provided by a Licensed Practitioner of the Healing Arts (LPHA), practicing within the scope of their own license and certification. This service includes treatment planning to enhance recovery and resiliency. *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)*

You may send your responses to The HARRIS CENTER in writing by the following:

Via e-mail to Stella.Olise@TheHarrisCenter.org

The HARRIS CENTER for Mental Health and IDD
YES Waiver Program
Attn: Stella Olise
6032 Airline Drive
Houston, Texas 77076
Drop off at the above location
Fax to (713) 970-4995

Questions regarding this process should be directed to the above address or:

Email: Dulce.Hernandez@theharriscenter.org or Stella.Olise@TheHarrisCenter.org
Phone: (713) 970-4385

7000.4 Family Supports

Service Description

Family supports provides peer mentoring and support to the primary caregivers; engages the family in the treatment process; models self-advocacy skills; provides information, referral and non-clinical skills training; maintains engagement; and assists in the identification of natural/non-traditional and community support systems. Family Supports are peer-to-peer mentoring services and are not clinical skills training.

Provider Qualifications

A family support provider must:

- have a high school diploma, or a high school equivalency certificate issued in accordance with the law of the issuing state; and
- pass a criminal history and background check [see POLICY [0 3100 Criminal History and Federal and State Registry Checks](#)].

In addition to at least one of the following:

- one cumulative year of receiving mental health community services for a mental health disorder; or
- one cumulative year of experience navigating the mental health system as the parent or primary caregiver of a child/youth receiving mental health community services; and
- be under the direct clinical supervision of a master's level therapist and receive, at a minimum, an hour of monthly supervision. The supervisor must document and maintain all supervision notes in the family support provider file.

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of family support services and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- title of evidence-based or best practice curriculum used;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant's response to the service provided;
- progress or lack of progress with service;
- summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider's printed name, signature, and credentials.

The provider must document the provision of service by maintaining up-to-date progress notes, which are reviewed by HHSC. All service documentation must be submitted within **two business days** after service delivery.

Non-Face-to-Face Contact with Participant

When Family Support Services provided to a participant are not face-to-face, the service is not billable, but the provider must document in the progress notes:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- description of the contact;
- service name and description;
- type of contact;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- need identified in the Wraparound Plan that the Family Supports service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant and/or Family Caregiver(s) response to Family Supports service provided;
- progress or lack of progress with Family Supports service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the Family Supports service addresses; and
- direct service provider's printed name, signature, and credentials.

Contact with Other Parties

When Family Support Services are provided face-to-face or provided over the phone with someone other than the participant, such as, but not limited to, the LAR, the provider must document in the progress notes:

- participant name;
- Medicaid ID #;
- date of the contact;
- service name and description;
- person with whom the contact was made;
- start and stop time of contact;
- reason for the contact;
- description of the contact;
- outcome(s) of the contact; and
- direct service provider's printed name, signature, and credentials.

Program Training

Prior to providing Waiver services and/or participating in a CFT meeting, a family support provider shall receive program training in accordance with [POLICY [0 3500 General Training and Technical Assistance](#)].

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for family supports is detailed in [POLICY [0 9000.4 Billing: Family Supports](#)].

9000.4 Billing: Family Supports

Unit Designation and Payment Rate

The unit designation for family supports is 15-minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Family support services are paid at the rate of \$6.25 per unit.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Group Setting Service(s)

Waiver services that are permitted to be provided in a group setting are billed using the following formula:

Number of providers × Time spent delivering service(s) ÷ Number of participants served = Billable Time.

Required Documentation

In order to properly bill for the provision of family support services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.

7000.9 Respite Services

Respite – In Home

Service Description

In-home respite service is provided on a short-term basis because of the absence of, or need for relief for, the LAR or other primary caregiver of a Waiver participant.

Limitations

A maximum of **720 consecutive or cumulative hours (30 calendar days)** of respite service of any type, or combination of any type, can be provided to a participant each service plan year.

In-home respite cannot be provided at the same time as:

- Supportive Family-Based Alternatives;
- Community Living Supports;
- Supported Employment;
- Employment Assistance;
- Non-Medical Transportation; or
- Paraprofessional Services.

In-home respite cannot be provided in a group setting. This service is intended as a one-to-one respite service for a single Waiver participant during a specific time period.

Federal financial participation is not to be claimed for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Settings

In-hom respite service is provided:

- within the State of Texas; and
- in the private residence of:
 - the participant; or
 - a relative of the participant other than the parents, spouse, legal guardian, or LAR.

Safety Checklist

The Waiver Provider agency must complete a Building Safety and Environmental Health Checklist prior to the provision of in-home respite service. The checklist is available under Forms and Templates section at:

<https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/yes/building-safety-environmental-health-checklist.pdf>.

Crisis and Safety Plan

The Waiver Provider agency must provide a copy of the participant's Crisis and Safety Plan to the respite provider.

Provider Qualifications

An in-home respite provider:

- must be at least 18 years of age;
- must have a current Texas driver's license;
- must pass a criminal history and abuse registry checks [see POLICY [0 3100 Criminal History and Federal and State Registry Checks](#)] and
- may be a relative of the participant other than the natural or adoptive parents, spouse, legal guardian, or LAR.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of in-home respite service and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant's response to the service provided;
- progress or lack of progress with service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider's printed name, signature, and credentials.

The provider must document the provision of in-home respite service by maintaining up-to-date progress notes, which will be reviewed by the Health and Human Services Commission. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

Program Training

Prior to providing respite services, an in-home respite provider must:

- receive program training in accordance with [POLICY [0 3500 General Training and Technical Assistance](#)]; and
- complete Electronic Visit Verification (EVV) training: <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/training-materials-resources>.

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for in-home respite is detailed in [POLICY 9000.10 BILLING: RESPITE, IN-HOME].

9000.9 Billing: Respite Services

Billing: Respite – In Home

Unit Designation and Payment Rate

The unit designation for in-home respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant, face-to-face.

In-home respite services are paid at the rate of \$20.88 per unit, and for one-to-one care of a single individual at the specified time.

Unit Limitation

Up to **720 consecutive or cumulative hours, or 30 calendar days**, of any respite service, or combination of respite services, is permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of in-home respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan; and
- information about the service provider, including:
 - printed name;
 - signature (electronic signature is acceptable); and
 - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

7000.26 Supported Employment

Service Description

Supported Employment means assistance provided, in order to sustain competitive and integrated employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported employment includes employment adaptations, supervision, and training related to an individual's assessed needs. Individuals receiving supported employment earn at least minimum wage (if not self-employed). Supported employment includes:

- employment adaptations;
- supervision; and
- training related to a participant's assessed needs.

Limitations

Supported employment cannot be provided at the same time as:

- Community Living Supports;
- Employment Assistance;
- Non-Medical Transportation;
- Paraprofessional Services; or
- Respite.

Transportation

Transporting an individual to support the individual to be self-employed, work from home, or perform in a work setting is billable within the service. This service is not available to individuals receiving Waiver services under a program funded under section 110 of the Rehabilitation Act of 1973.

Documentation must be maintained in the participant's file that the service is not available to the participant under a program funded under the Individuals with Disabilities Education Act (20 U.S.C §1401 et seq.).

Personal Assistance

If a participant requires personal assistance with activities of daily living that are necessary to sustain the participant's work environment and are incidental to the provision of supported employment, the supported employment provider is permitted to deliver personal assistance.

Incentives, Subsidies, and Certain Expenses

This service does not include sheltered work or other types of vocational services in specialized facilities, or for incentive payments, subsidies, or unrelated vocational training expenses such as:

- incentive payments made to an employer to encourage hiring the participant;

- payments that are passed through to the participant;
- payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
- payments used to defray the expenses associated with starting up or operating a business.

Provider Qualifications

A provider of supported employment must:

- be at least 18 years of age;
- maintain a current driver's license, and insurance if transporting the participant;
- pass a criminal history and background check [see POLICY [0 3100 Criminal History and Federal and State Registry Checks](#)]; and
- have one of the following:
 - a bachelor's degree in rehabilitation, business, marketing, or a related human services field and six months of paid or unpaid experience providing services to people with disabilities;
 - an associate's degree in rehabilitation, business, marketing, or a related human services field and one year of paid or unpaid experience providing services to people with disabilities; or
 - a high school diploma or certificate of high school equivalency (GED credentials) and two years of paid or unpaid experience providing services to people with disabilities.

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Documentation of supported employment must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- title of evidence-based or best practice curriculum used;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant's response to the service provided;
- progress or lack of progress with service;
- summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider's printed name, signature, and credentials.

The provider must document the provision of supported employment by maintaining progress notes detailing the activity the participant engaged in with the service provider, which will be reviewed by the HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

Program Training

Prior to providing Waiver services and/or participating in a CFT meeting, a supported employment provider must receive program training in accordance with [POLICY [0 3500 General Training and Technical Assistance](#)].

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for employment assistance is detailed in [POLICY 9000.20 BILLING: SUPPORTED EMPLOYMENT].

9000.20 Billing: Supported Employment

Unit Designation and Payment Rate

The unit designation for supported employment is 15 minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Supported employment services are paid at the rate of \$6.52 per unit.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Required Documentation

In order to properly bill for the provision of supported employment services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.

7000.6 Non-Medical Transportation

Service Description

Non-medical transportation enables Waiver participants to gain access to Waiver and other community services, activities and resources, as specified by the Wraparound Plan. This service is in addition to, not instead of, medical transportation required under 42 CFR §431.53 and transportation services under the State Plan. Transportation services under the Waiver are offered in accordance with the Waiver participant's service plan. This service shall be made available after other transportations already available through formal and natural supports have been exhausted.

Provider Qualifications

A provider of non-medical transportation must:

- be over the age of 18;
- have a valid Texas driver's license and insurance appropriate to the vehicle used to provide the transportation; and be a:
- member of the Waiver Provider agency staff; or
- direct service provider subcontracted with the Waiver Provider agency; and
- pass a criminal history and background check [see POLICY [0 3100 Criminal History and Federal and State Registry Checks](#)].

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

Relatives as Providers

A participant's LAR is not permitted to be reimbursed by Medicaid for the provision of non-medical transportation.

A relative of a Waiver participant must meet all provider qualifications above in order to be reimbursed by Medicaid for the provision of non-medical transportation.

Wraparound Plan

The Wraparound Plan must describe how the use of non-medical transportation will assist the participant in achieving their identified need(s), as linked to their SED.

Progress Notes

Documentation of non-medical transportation in a transportation log or alternative mileage log must include:

- participant name;
- Medicaid ID #;

- date of contact;
- start and stop time of contact;
- need identified in the Wraparound Plan that the non-medical transportation service will address;
- start and end location name;
- start address and end address;
- number of miles driven each way;
- total number of miles driven per page and final collective total; name of service provider; and
- direct service provider's signature and credentials.

A sample transportation log is available on the YES Waiver web site at:

<https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers/yes-waiver-resources>.

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for non-medical transportation is detailed in [POLICY [0 9000.6 Billing: Non-Medical Transportation](#)].

9000.6 Billing: Non-Medical Transportation

Unit Designation and Payment Rate

The unit designation for non-medical transportation is one mile. One mile is billed as one unit. In order to bill for a unit, it must be provided to the participant, face- to-face.

Mileage incurred prior to picking the participant up or after dropping the participant off to access Waiver services are not units and cannot be billed.

Non-medical transportation is paid at the rate of \$0.55 per unit.

Limitations

Payment for non-medical transportation is limited to the costs of transporting a participant to and from Waiver services included in the service authorization, or to access other activities and/or resources identified in the service authorization.

Whenever possible, members of the participant's family, neighbors, friends, or community agencies which can provide non-medical transportation at no cost must be utilized prior to requesting it through the Waiver.

When costs for transportation are included in the provider rate for another Waiver service the participant is receiving at the same time, non-medical transportation will not be reimbursed separately as a Waiver service.

Non-medical transportation cannot be provided at the same time as:

- Community Living Supports;
- Supported Employment;
- Employment Assistance; or
- Paraprofessional Services.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Required Documentation

Providers are required to maintain a transportation log documenting the use of this service. The log may be requested during quality management audits. A template is available on the YES Waiver website. In order to properly bill for the provision of non-medical transportation, a provider must document:

- date of contact;
- mileage, including start and stop time; and
- direct service provider's printed name, signature, and credentials.

Rounding Mileage

Mileage is rounded to the nearest whole mile, in accordance with the following:

Mileage	Round
.01-.49	Down
.50-.99	Up

Reimbursement and Negotiation Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate. The CWP is permitted to negotiate payment to its employees or subcontractors.

7000.9 Respite Services

Respite – Out-of-Home Camp

Service Description

Out-of-home respite service at a camp is provided on a short-term basis because of the absence of or need for relief for the LAR or other primary caregiver of a YES Waiver participant.

Limitations

A maximum of **720 consecutive or cumulative hours (30 calendar days)** of respite service of any type, or combination of any type, can be provided to a participant each service plan year.

Respite at a camp cannot be provided at the same time as:

- Supportive Family-Based Alternatives; or
- Community Living Supports;
- Supported Employment;
- Employment Assistance;
- Non-Medical Transportation; or
- Paraprofessional Services.

Federal financial participation is not to be claimed for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Provider Qualifications

Day or overnight camp respite service is provided only by camps that are licensed by the state of Texas or accredited by the American Camp Association (ACA).

An out-of-home camp provider:

- must be at least 18 years of age;
- must have a current Texas driver's license;
- must pass a criminal history and abuse registry checks [see POLICY [0 3100 Criminal History and Federal and State Registry Checks](#)].

Department of State Health Services

Out-of-home respite service is provided by camps that are licensed and adhere to 25 TAC 265, Subchapter B.

American Camp Association

Out-of-home respite service is also provided by camps that are accredited by the American Camp Association. Accreditation requirements and standards for the American Camp Association are available at: <http://www.acacamps.org/accreditation>.

Crisis and Safety Plan

The Waiver Provider agency must provide a copy of the participant's Crisis and Safety Plan to the respite provider.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of respite service provided by a camp and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant's response to the service provided;
- progress or lack of progress with service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider's printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

Program Training

Prior to providing respite services, an out-of-home respite provider must receive program training in accordance with [POLICY [0 3500 General Training and Technical Assistance](#)].

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite provided by a camp is detailed in [POLICY 9000.11 BILLING: RESPITE, OUT-OF-HOME: CAMP].

9000.9 Billing: Respite Services

Billing: Respite – Out-of-Home Camp

Unit Designation and Payment Rate

The unit designation for out-of-home camp respite services is a 15-minute unit rate. One hour is billed as four units. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Out-of-home camp respite services are paid at the rate of \$2.46 per unit.

Incremental Billing

HHSC permits out-of-home camp respite services to be billed in 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit
15	1.0
30	2.0
45	3.0
60	4.0

Unit Limitation

Up to **720 consecutive or cumulative hours, or 30 calendar days**, of any respite service, or combination of respite services, is permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of out-of-home camp respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
 - printed name; signature (electronic signature is acceptable); and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

7000.9 Respite Services

Respite – Out-of-Home Licensed Childcare Center

Service Description

Out-of-home respite service at a Licensed Child Care Center (LCCC) is provided on a short-term basis because of the absence of or need for relief for the LAR or other primary caregiver of a YES Waiver participant.

Respite provided by a LCCC is divided into preschool age and school age groups, in accordance with the following:

Preschool Age

Preschool age respite is provided for youth ages 3 to 5 years old.

School Age

School age respite is provided for youth who are 6 through 18 years of age.

Provider Qualifications

An out-of-home licensed childcare center provider:

- must be at least 18 years of age;
- must have a current Texas driver's license;
- must pass a criminal history and abuse registry checks [see POLICY [0 3100 Criminal History and Federal and State Registry Checks](#)].

Limitations

A maximum of **720 consecutive or cumulative hours (30 calendar days)** of respite services of any type, or combination of any type, can be provided to a participant each service plan year.

Respite at a LCCC cannot be provided at the same time as supportive family-based alternatives or community living supports.

Provider Qualifications

A respite service provider must be a childcare center licensed by the DFPS, in accordance with 26 TAC 746.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of respite service provided by a LCCC and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant's response to the service provided;
- progress or lack of progress with service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider's printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to- date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

Program Training

Prior to providing respite services, a LCCC respite provider must receive program training in accordance with [[POLICY 0 3500 General Training and Technical Assistance](#)].

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite service provided by a LCCC is detailed in [POLICY 9000.12 BILLING: RESPITE – OUT-OF-HOME LICENSED CHILDCARE CENTER].

9000.9 Billing: Respite Services

Billing: Respite – Out-of-Home Licensed Childcare Center

Unit Designation and Payment Rate

The unit designation for out-of-home LCCC respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

LCCC respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of \$5.32 per unit.

School Age

LCCC respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of \$5.17 per unit.

Incremental Billing

HHSC permits LCCC respite services to be billed in $\frac{1}{4}$, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75

Minutes	Unit
60	1.0

Unit Limitation

Up to **720 consecutive or cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, is permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of LCCC respite services, a provider must document:

- date of contact;
- start and stop time;

Exhibit C8

- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- a summary of activities, meals, and behaviors; and
- information about the service provider, including:
 - printed name;
 - signature (electronic signature is acceptable); and
 - credentials.

Reimbursement and Negotiation of Service Rate

HHSC shall directly reimburse the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

7000.26 Supportive Family-Based Alternatives

Service Description

Supportive Family-Based Alternatives are designed to provide therapeutic support to the Waiver participant and to model appropriate behaviors for the Waiver participant's family with the objective of enabling the Waiver participant to successfully return to their family and live in the community with their family.

Supportive family-based alternatives include services required for a Waiver participant to temporarily reside within a home other than the home of their family.

The support family must include at least one adult living in the home and no more than four non-related individuals may live in the home. The support family must have legal responsibility for the residence and either own or lease the residence. The home must be located in a typical residence in the community and provide an environment that assures community integration, health, safety and welfare of the Waiver participant. The support family must provide services as authorized in the Waiver participant's service plan.

Services may include:

- age and individually appropriate guidance regarding and/or assistance with the activities of daily living and instrumental activities of daily living (ambulating, bathing, dressing, eating, getting in and out of bed, grooming, personal hygiene, money management, toileting, communicating, performing household chores, and managing medications);
- securing and providing transportation;
- reinforcement of counseling, therapy, and related activities;
- assistance with medications and performance of tasks delegated by a registered nurse or physician;
- supervision of the participant for safety and security;
- facilitating inclusion in community activities, social interaction, use of natural supports, participation in leisure activities, and development of socially valued behaviors; or
- assistance in accessing community and school resources.

Limitations

Pre-Authorization

Supportive family-based alternatives (SFA) must be pre-authorized by HHSC and can be authorized for up to **90 consecutive or cumulative calendar days**, per IPC year.

Costs Not Covered

Costs that are not included in the payment of SFA are:

- room and board, as the participant is responsible for costs associated with room and board; and
- transportation, which is included in the provider rate.

Other Services

The participant cannot receive respite or community living support services while receiving SFA. In addition, a participant who is eligible for, or receiving, Title IV-E services cannot receive SFA.

Support Family Requirements

The support family must:

- include at least one adult residing in the home who:
 - is at least 18 years of age;
 - is not the parent, spouse, legal guardian or LAR of the participant;
 - has a current Texas driver's license;
 - has insurance appropriate to the vehicle used to provide transportation;
 - be CPR and first aid trained and certified; and
 - pass a criminal history and background check [see POLICY [0 3100 Criminal History and Federal and State Registry Checks](#)];
- not have more than four non-related individuals residing in the home;
- have legal responsibility for the residence and either own or lease the residence;
- reside in a home located in a typical residence in the community;
- provide an environment that assures the community integration, health, safety, and welfare of the participant; and
- provide services in accordance with the participant's service authorization.

Provider Qualifications

SFA services may be provided through one of the following:

- **foster family:** a foster family verified with DFPS in accordance with 26 TAC 749.
- **child placing agency:** a child placing agency licensed with DFPS, in accordance with 26 TAC 749. The child placing agency must recruit, train, and certify the support family and coordinate with the support family.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;

- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of SFA services and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- title of evidence-based or best practice curriculum used;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant's response to the service provided;
- progress or lack of progress with service;
- summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider's printed name, signature, and credentials.

The provider must document the provision of SFA services by maintaining up-to- date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the participant and LAR in the YES Waiver program.

Program Training

Prior to providing Waiver services and/or participating in a CFT meeting, a SFA provider must receive program training in accordance with [POLICY [0 3500 General Training and Technical Assistance](#)].

Billing

Costs for all Waiver services, including any extended Supportive Family-based Alternatives cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for SFA is detailed in [POLICY [0 9000.21 Billing: Supportive Family-Based Alternative](#)].

9000.21 Billing: Supportive Family-Based Alternative

Unit Designation and Payment Rate

The unit designation for SFA is daily. Any portion of a 24-hour period is permitted to be billed as one unit.

Support Family

SFA services provided by a support family are paid at the rate of \$69.25 per unit, the mandated minimum in accordance with 40 TAC §700.1753.

Child Placing Agency

SFA services provided by a child placing agency are paid at the rate of \$67.98 per unit.

Unit Limitation

Up to **90 consecutive or cumulative calendar days** of SFA are permitted to be provided, per participant, per IPC year.

Required Documentation

In order to properly bill for the provision of SFA service(s), a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate. The CWP is permitted to negotiate payment to its employees or subcontractors for services provided by a child placing agency; however, a support family must be paid the entire mandated maximum rate.