Department of Health and Human Services

Division of Vocational Rehabilitation Services

Policy Directives

Independent Living Services Program

Effective Date: July 1, 2010

Revision Date: July 15, 2020

Volume VIII Policy Directives

Click on the links below to view the corresponding directive

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Year Issued: 2004

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#8-2007 - VR/IL Concurrent Records of Service for PAS - Revised

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#05-2020 - Using Approved Videoconferencing Technologies to Provide Services Remotely

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#07-2020 - Purchasing Face Coverings for Clients

North Carolina
Department of Health and Human Services
Division of Vocational Rehabilitation Services

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August 27, 2003

MEMORANDUM

To: All Staff Assigned Volume I

From: Georgia Steele, Assistant Director
Program Operations and Support Services

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #1**

Please create a new tab in your Appendix for "Policy Directives" following appendix section "P" and file Interim Policy Directive #1 in the Appendix in the new section. This section will be utilized to file information previously sent out as informational memos from multiple sources. The Directives will be numbered differently in order to distinguish the directive from Policy Transmittals.

Policy Directive #1 addresses the recent changes in CATS and IMS edits to insure accurate reporting to RSA. This Policy Directive must be followed until a Policy Transmittal or another Policy Directive replaces the content of the directive.

Please address questions regarding the reporting issues to Marjorie Donaldson.

North Carolina
Department of Health and Human Services
Division of Vocational Rehabilitation Services

Michael F. Easley, Governor
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POLICY and PROCEDURE DIRECTIVE MEMORANDUM # 1

TO: Regional Directors, Unit Managers, Quality Development Specialists, Counselors

FROM: Marjorie Donaldson, Chief of Planning and Development

SUBJECT: Client Data Input and Data Maintenance Changes

DATE: August 27, 2003

As discussed at the August 6, 2003 Management Team meeting, there are several issues regarding the input and upkeep of client data that have to be addressed immediately in order to comply with RSA requirements and all federal reporting due to increasing and substantial errors.

Therefore, effective immediately, the following areas will be mandatory and edits will be in place to assure compliance:

Primary Support: Must be reported at application and updated at closure.

Public Support: Must be reported at application; reviewed at the time of eligibility; and updated at closure. The amount received by the individual each month for each source of public support must be recorded.

In addition, an edit will be in place to disallow public support amounts exceeding $4,000. If there is a legitimate case where the amount exceeds $4,000, please contact Jennifer Mitchell.

Medical Benefits: **Must be reported at application and updated at closure. Each type requires a response either yes or no, and cannot be skipped.**

Veteran Status: A response either yes or no is required. This field cannot be skipped.

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Social Security Numbers: Input of the SSN has to be done before any type of case closure including "08's (closure from applicant status).

IPE date and Closure date: There have been hundreds of cases over the past two years where the IPE date input was prior to the eligibility date. In addition, cases were closed with a date prior to the application date. An edit will be in place to prevent this from occurring.

Extended Employment: Closure reason 14 (extended employment) is only allowed for status 28 closures.

Significant Medical Improvement

Input of this information will no longer be required.

Backdating of Status 12

Recently, there has been a noticeable increase in requests to Jennifer Mitchell to backdate cases in status 12. The majority are cases where staff indicated that they failed to input a status change from status 10 to 12 in CATS or failed to do so at the time they developed an IPE. Requests recently from staff have been to backdate status 12 as far back as April of last year. Jennifer will assist staff with backdating status changes as long as it is within the current quarter and does not cross state or federal fiscal years.

As you are aware, the Division submits quarterly and annual federal reports to the Rehabilitation Services Administration (RSA) as required by the Rehabilitation Act and regulations. Much of the quarterly data reported is based on eligible clients with a plan for services. This information has to remain constant once reported. Therefore, please remind staff to check their masterlists more frequently to minimize the number of cases on a monthly basis that require backdating.

As noted previously, edits will be in place for both CATS and IMS to assure that this data is captured as indicated. Cats will bring forward on the closure screen the level of education, public support and medical benefits that were input at application. The counselor will be required to verify these and adjust any fields that are different at the time of closure in order to maintain correct data.

Required Verification Checks

RSA also conducts what it deems "reasonableness checks" of the data submitted. These areas are not necessarily errors **but do require verification**. Many of you have been asked to verify the accuracy of such data in the past. The major areas that fall under this category are:

- Verification of amounts of SSI, VA, other public support greater than $4000.

- Verification of cases with closures of successful outcome and unsuccessful outcomes after services have been provided that have no cost.
- Verification of cases with costs greater than $100,000.
- Verification of cases with time spent in VR less than three days.
- Verification of cases with age greater than 75 at time of application.
- Verification of cases with age less than 14 at time of application.
- Verification of cases in VR greater than 12 years.
- Verification of hourly wages greater than $50/hour at application and /or closure.

Missing Data Report for Field Staff Use

Effective this month, a new report has been generated and is available on EXPORTER. It is labeled: VCMB970 RSA Data Miss.-Mo. **located under** DHR/VRA **in EXPORTER. This report is available for each caseload. Security is set up so that a counselor can only look at his/her own caseload. Managers and QDS's will have access to their multiple caseloads. The purpose of this report is to provide a mechanism for counselors and office assistants to know what cases require corrective action and allow them to make those corrections. This report indicates both errors and data that need verification. Please have your staff move this new report (VCMB970) to their favorites list in EXPORTER.**

Currently, there are approximately 10 pages of missing data per caseload on this report. This represents a number of older cases that have been closed during the federal fiscal year that will end next month. Therefore, it is very important that staff work now to correct the areas noted on their caseload's report before the end of September. Jennifer Mitchell will be available to assist staff with this process and she will, as you know, be the person who will need to confirm this data prior to reporting. Jennifer will start reconciling this data in October to be submitted for the RSA-911 report for federal fiscal year 2002-2003.

Items on this report that require verification, as noted above, will not drop off the counselor's report and will remain there each month. The counselor or office assistant will be required to send via email, a response to Jennifer confirming the action taken on these items (correction or verification of accuracy). Once this is sent to Jennifer, no further action should be necessary.

The **VCMB970 RSA Data Miss. Report** will be available monthly for on-going caseload maintenance. Once the large amount of data noted previously is corrected and/or provided on these older cases, subsequent monthly reports should be considerably smaller. A "tickler" reminder will be generated for each caseload counselor via CATS regarding the need to address errors/missing data.

The client data reports the Division submits to RSA is the primary basis by which the VR program is evaluated. When errors occur, the Division is required to correct it quickly. Therefore, it is critical that we all put forth strong effort to get it right initially.

Thank you for your attention to this matter. Please contact Jennifer Mitchell or me if you have any questions.

North Carolina
Department of Health and Human Services
Division of Vocational Rehabilitation Services

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October 21, 2004

MEMORANDUM

To: All Staff Assigned Volume I

From: Georgia Steele, Assistant Director
Employment Services

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #06**
DURABLE MEDICAL EQUIPMENT

Please utilize the following policy and procedure for purchasing the specific durable medical equipment and assistive technology referenced in this memo until it is replaced by a subsequent policy directive or revision. This policy directive is effective immediately.

1. **Wheelchairs**
   - A prescription is required in order to purchase a wheelchair
   - If purchased from vendors that have been awarded a state term contract the Division will pay up to that rate after all other resources and comparable benefits have been utilized to pay for the wheelchair. The vendor is required to file for any comparable benefit available.
   - If purchased from other vendors with justification as defined in Section 2-5-5, VR will solicit three written bids, take the lowest bid and pay up to that rate after all comparable benefits have been utilized.
   - The vendor is required to file for any comparable benefit available. The benefit may be filed unassigned (this means that the money goes to the client instead of the vendor). This enables the vendor to blend sources of funding for components that are not covered by the comparable benefit.

- This procedure has not changed from previous practice. If the cost of the chair is estimated to be over $2500.00, a purchasing packet must be forwarded to the Purchasing Unit for bids and purchasing.

2. **Augmentative Communication Devices:** These devices to not have a set rate or a Medicaid rate.
    - A prescription is required in order to purchase augmentative communication devices
    - The Purchasing Unit will be responsible for purchasing this equipment as it is generally in excess of $2500.00.
    - The Division will pay up to the rate of the lowest bid after all comparable benefits and resources have been utilized to purchase the device. The vendor is required to file for any comparable benefit available. This procedure has not changed from previous practice.

3. **Lift chairs**: Lift chairs do not have a set rate or a Medicaid Rate
    - A prescription and a Certificate of Medical Necessity is required to purchase this durable medical equipment
    - Since these chairs cost under $2500.00, the bid process may be initiated locally. Three written quotes must be solicited and the lowest quoted rate accepted for the chair.
    - The vendor is required to file for any comparable benefits available and apply that to the cost of the lift chair.
    - NOTE: If the individual has a wheelchair previously sponsored by Medicare, the comparable benefit will not pay for a lift chair. Document this in the record to explain why the vendor does not file for the comparable benefits in this case

4. **Multiple items of Durable Medical Equipment purchased as a package**: a number of small items is purchased together in which some have Medicaid rates and some do not:
    - Solicit quotes as a package
    - Accept the lowest quote
    - Submit the invoice for the entire amount
    - The Division will pay the amount for the entire package
    - Do not itemize separately with “E” codes in this case

For all other durable Medical Equipment and Medical Equipment, the Medicaid rate or the Division’s set rate will be paid. If there is no rate, contact Michelle Stephenson for clarification of the Medicaid rate or for the Division’s set rate.

GS:tf

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MEMORANDUM

To: All Staff Assigned Volume I

From: Brenda S. Williamson, Assistant Director, Employment Services BSWilliamson
Carol Potter, Assistant Director, Community Services CLPotter

Date: February 9, 2006

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #01-2006**
VR and IL Personal Assistant Services – SECTION 2-18

The purpose of this directive is to bring the VR/IL Personal Assistance Services policy (SECTION 2-18) up to date with IRS requirements and to insure, to the extend possible, that our clients/participants are in compliance with the law so that they do not incur penalties for being delinquent in the payment of the FICA tax. Also, VR counselors are increasingly utilizing personal assistance services with clients, particularly in instances where the client is the actual employer of the personal assistant instead of securing this service through traditional home health agencies. In these cases, we are adding procedures to help insure that client's are fulfilling their responsibilities in paying the federal household employer (FICA) tax.

VR counselors must follow the IL Personal Assistance Services Policy (SECTION 2-18-1 Participant as Employer) when the client is the employer of the attendant. The Controller's Office will no longer process payment for VR personal assistance services unless the IL policy is followed in these situations.

This policy directive also addresses new procedures for client/participants in maintaining tax withholdings on their attendants when the client/participant is the employer of the personal assistant. Clients/participants are required to pay federal household employer (FICA) tax either quarterly or annually depending on their individual circumstances. The client/participant is responsible for determining what his/her obligation is for schedule of payment of FICA taxes, either with or without

assistance from an accountant or bookkeeper. There are numerous variables that must be taken into account in determining if the federal household employer tax (FICA) is to be paid either quarterly or annually. **It is not the role of the VR/IL State Agency to make these determinations for the client/participant.** If we were to attempt this and make incorrect determinations, the division would be liable for the payment of penalties.

The Division is no longer providing the FICA tax to the client/participant on a bi-weekly basis as it has in the past. Our policy heretofore has stated that "It is the responsibility of the participant to save the FICA taxes received and withhold until the end of each calendar year when those taxes are to be submitted to the IRS". In the future, these funds will not be released until they are needed for the quarterly or annual payment of FICA, whichever is applicable. Clients/Participants must determine their own individual schedule of payment of the FICA tax and document such on the new DVR Form 1022A, to be submitted to their rehabilitation counselor. For the current tax year 2006, clients/participants should submit this form to their counselors by March 1, 2006, so that the division can provide them the FICA money in time to pay their first quarterly tax payment (if applicable) for the current tax year 2006.

Revised Policy

Volume I, Section 2-18 - "Participant Employer-Related Tax Obligation", Number 3 (FICA Taxes), is revised to state that at the end of each pay period, the participant will be reimbursed for only the net wage based on form DVR-1019 "Record of Personal Assistant Hours" (timesheet) that the participant submitted to their counselor. The client/participant shall complete and return Form DVR-1022A and return it to their counselor by March 1 of each year or within twenty-one (21) days after actually hiring their first personal assistant(s). In the future, it is the responsibility of the participant to pay the FICA tax either quarterly or annually as they have determined on Form DVR-1022A. The client/participant shall pay the FICA tax as specified on the "Federal/State Household Employer Tax Payment Schedule" provided by the counselor. Within seven (7) days of paying the federal/state household employer tax, the client/participant will complete form DVR-1022B "Payment of Federal/State Household Employer Taxes" and return it to their counselor.

Due to the fact that the client/participant needs to complete and return form DVR-1022A to their counselor by March 1, 2006, it is necessary for staff to immediately provide the client/participant with copies of the following forms:

- Form DVR-1022A "Payment of Federal Household Employer Tax" is a new form. The participant will need to complete this form and return it to their counselor by March 1, 2006.

- Form DVR 1019A "Personal Assistance Services Receipt" has been revised to remove the language regarding the FICA amount being withheld in the checking account.

- Form DVR-1022B "Payment of Federal/State Household Employer Taxes" is a new form. The participant will need to complete this form and return it to

their counselor after paying their federal and state taxes.

- "2006 Federal/State Household Employer Tax Payment Schedule for Participant Use"
- "2006 Federal/State Household Employer Tax Payment Schedule For Staff Use Only"

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MEMORANDUM

To: All Staff Assigned Volume I

From: Elizabeth W. Bishop – Section Chief, Program Policy, Planning and Evaluation

Date: February 20, 2007

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #01-2007**
Workplace Violence

The Division is committed to providing a safe and secure setting for employees to conduct their important work for the clients they serve. Likewise, we are also committed to providing a safe professional environment where client's can meet with vocational rehabilitation professionals to address their issues. We realize at times there can be situations in which applicants and clients become volatile or unstable to some degree. In many situations, this may be the focus of our vocational rehabilitation counseling in helping clients develop effective strategies in problem-solving difficult situations. However, clients are expected to follow societal codes of conduct and laws as set forth under our state and Federal statutes when conducting business and interacting with Division employees. The Division cannot tolerate behavior that is threatening, hostile, harassing, violent, intimidating, damaging to property, or physically aggressive to employees or others in the work environment, or when employees are in the community. Threatening behaviors could be made by phone, by mail, on site, after business hours, or in connection with other VR service providers such as Community Rehabilitation Programs (the respective policies of CRP would be applicable as well).

Definitions

- **Workplace Violence**: For purposes of casework and client services, workplace violence entails violence that may be carried out by consumers of services, their friends, relatives, strangers or acquaintances, and vendors either in an office setting or field location.

- *For issues involving staff against staff workplace violence, please refer to policies through the Office of State Personnel and Department of Health and Human Services. The web links for these policies are:*
  Office of State Personnel - http://www.osp.state.nc.us/manuals/manual99/workplvi.doc
  Department of Health and Human Services - http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-50/man/Pol5

- **Threat**: The expression of intent to cause physical or mental harm. An expression constitutes a threat without regard to whether the party communicating the threat has the present ability to carry it out and without regard to whether the expression is contingent, conditional or future.
- **Intimidation** – Actions that include but are not limited to stalking or behavior intended to frighten, coerce, or induce duress
- **Harassment**: This is an unwanted persistent behavior against another person which results in physical or emotional intimidation.
- **Physical Attack**: Unwanted or hostile physical contact such as hitting, fighting, pushing, shoving, throwing objects, use of firearms or any weapons, or devices which would cause bodily harm.
- **Property Damage**: Intentional damage to property and includes property owned by the State employees, their consumers of services, visitors or vendors.
- **Improper Use of Internet/Telephone**: the use of various communication mediums to relay harassing statements or threats.
- **NOTE**: These guidelines do not apply to behaviors, statements, or actions which are inappropriate, offensive, irritating, or otherwise troublesome in nature. Such actions and behaviors are sometimes encountered by counseling professionals and other staff who work with people who have significant mental and/or physical disabilities. As professionals, we are expected to handle such actions and behaviors in a competent, efficient, and understanding manner. Supervisory and administrative consultation should be obtained whenever needed, but especially whenever it is felt that an action is becoming or constitutes a threat, violence, harm, harassment, or other form of intimidation. Unless an individual's action or behavior rises to the level of a threat, violence, harm, harassment, or other form of intimidation, it is expected to be treated, and responded to in a professional manner.

Each office must have emergency protocols for dealing with potentially dangerous or violent situations (this should be a type of alarm, warning system, or code words that will alert others to the fact that help is needed or that the police need to be called by someone other than the individual in the situation). If in an employee's judgment a situation requires immediate action, employees should attempt to utilize strategies of de-escalation. However, if an immediate danger exists, the police shall be contacted promptly. If a physical threat is taking place the threatened person should disengage from the threatening person involved as quickly as possible and obtain support from all other people in the vicinity. Consultation with supervisors and administration should be sought immediately. All other individuals in the vicinity should be informed that a threatening incident is occurring or has occurred. If someone is being physically attacked, and it is no longer a threat, that person has the right to defend himself or herself immediately, to escape or disengage from the situation, and to immediately seek all available assistance and support.

All threats, violence, harm, harassment, and other forms of intimidation must be documented using the *Workplace Violence Incident Report Form*. This form must be submitted to the most immediate and available supervisor, even when there is an uneventful or favorable resolution of the incident. Management, in consultation with Human Resources Staff and affected employee(s), will determine a measured response and course of action to take and initiate such, factoring in the perceived seriousness of the situation and need to involve others such as law enforcement.

When an individual demonstrates by past or present actions that they pose a threat to Division staff, they have forfeited the benefit to receive vocational rehabilitation services. The Chief of Policy and Casework Operations, or Section Chief for Policy, Planning & Evaluation should be consulted **in all such cases**.

1. If there is an open case, the case should be closed as *"failure to cooperate"*. The individual should be notified in writing of the closure, the reason for the closure (the individual's behavior which was identified as violent or threatening), the State's workplace violence policy, and the standard rights to appeal.
2. Requests to open new cases or reopen previously closed cases should be assessed very carefully. The individual must provide independent evidence that they have received services or therapy to address the previously identified violent or threatening behavior. It is the individual's responsibility to provide such evidence. Independent sources for such evidence and evaluation may be a psychiatrist, psychologist, medical doctor, or other professional whom the counselor deems qualified to assess such situations. Participation in such services or therapy alone does not equate to eligibility for Vocational Rehabilitation services. The individual would still have to be determined eligible according to the standard eligibility policies and procedures. If a case is not opened or reopened, the individual should be notified in writing of the Division's decision, the reason for the action, the State's workplace violence policy, and the standard rights to appeal.

All VR Offices should have the weapon frees/prohibition policy posted.

WORKPLACE VIOLENCE INCIDENT REPORT – VOLUME I

Reporting Individual: _____

VR Work Unit: _____

Name of Intended Victim: _____

Date of Incident: _____

Specify Location of Incident: _____

TYPE OF INCIDENT: **(Check one or more)**

Threat:

- ☐ **Communicated directly to victim**
- ☐ **Communicated to another person**
- ☐ **Other (Specify)** _____

_____

- ☐ **Verbal**
- ☐ **Mail**
- ☐ **Note**
- ☐ **E-Mail**

Intimidation:

- ☐ **Stalking**
- ☐ **Engaging in actions intended to frighten, coerce, or induce duress**
- ☐ **Other (Specify)** _____

Physical Attack:

- ☐ **Hitting, fighting, pushing, or shoving**
- ☐ **Use of object as weapon**
- ☐ **Use of weapon such as gun or knife**
- ☐ **Other (Specify)** _____

Property Damage:

- ☐ **Damage to State Property**
- ☐ **Damage to personal property**
- ☐ **Other (Specify)** _____

Name of Perpetrator (If Known) _____

If not Client, Relationship to Client _____

Please describe in your own words the workplace violence incident that took place and any relevant background information (Use additional pages if necessary).

_____

_____

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_____

Please attach any supporting information (i.e., copies of emails, letters, and/or pictures).

Name of Reporting Person: _____

Signature of Reporting Person: _____

Date: _____

North Carolina
Department of Health and Human Services
Division of Vocational Rehabilitation Services

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MEMORANDUM

To: All Staff Assigned Volume I

From: Elizabeth W. Bishop – Section Chief, Program Policy, Planning and Evaluation

Elizabeth W Bishop

Date: February 20, 2007

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #02-2007**
VR Sponsorship of Prescription Pain Medications

The purpose of VR sponsorship of physician prescribed pain medication is to make an individual's pain more tolerable during the recovery process from physical impairments and/or to help the individual be more functional and able to participate in their vocational rehabilitation program. These medications have very strong addictive potential. There is the potential for overdose if not taken as instructed by a physician. They also present significant risk for abuse and misuse.

The following guidelines must be followed by rehabilitation counselors when authorizing this service:

1. All prescriptions for the client must be provided by one treating physician. If the client has a history or current diagnosis of substance abuse/dependence, he/she must sign VR Consent for Release of Confidential Information Form allowing the Division to release this information regarding past or current substance abuse to the treating physician.

2. VR sponsorship of these medications should not exceed a period of sixty days. The one exception is that a unit manager may approve an extension of the sixty day limit for a specified, limited, time if the client is actively being treated in a chronic pain clinic and under the medication protocols of that clinic. However, the Division is unable to purchase prescription pain medications on a long term basis for chronic pain disorders. In these

situations, efforts must be made to identify long term funding sources for the prescribed medications.

3. The treating physician will provide the vocational rehabilitation counselor with a brief treatment plan for the patient. The counselor will be notified in writing of any significant changes or amendments to this plan.

4. If the patient is referred to another physician who will become the treating physician, the patient will sign a release allowing notification of the new physician of the patient's controlled substance use.

5. The client must sign a VR Narcotics Contract which will be in effect for the duration of the service.

6. VR will not authorize replacements of medications that are lost, stolen, damaged, destroyed, thrown away, etc.

7. The client must inform the treating physician and rehabilitation counselor if he/she is receiving prescriptions for pain medications from any other physician. Failure to do so will result in the Division terminating sponsorship of this service.

The treating physician should provide periodic blood or urine testing of the patient. This helps to identify patients who are using additional drugs, using excessive amounts of the prescribed drug or not using any medication at all.

North Carolina Division of Vocational Rehabilitation
Prescription Pain Medication Contract

1. The purpose for my using the medications is to make my pain more tolerable during the recovery process from physical impairments. Additionally, these medicines are used to help me be more functional in being able to participate in my vocational rehabilitation program and secure suitable employment. VR authorization of these medications will be for the quantity indicated on the prescription not to exceed a supply covering 60 days (the equivalent of a prescription for a one month and one refill)

2. I understand that these medications have very strong addictive potentials. There is potential for being overdosed if not taken as instructed by my physician. I am to take these medications exactly as prescribed by my physician.

3. I understand that if my tolerance for these medications becomes too great that my physician may put me on a drug holiday (that is, taken off these medications) so that my body can readjust to function at a much lower level or no drug level.

4. I will obtain these medications only from the treating physician identified in my rehabilitation plan (IPE). I will not seek these medicines from any other physicians. I will make other treating physicians aware of my Prescription Pain Medication Contract with NC DVR.

5. I must notify my rehabilitation counselor in advance of needing authorization of a refill.

6. There will not be replacement of medications that are lost, stolen, damaged, destroyed, thrown away, etc. I will store these medicines in a safe place away from children.

7. I will tell my treating physician and rehabilitation counselor if I am getting these medicines from any other physicians.

8. If I do not follow the guidelines in this contract, I will no longer receive assistance from NC DVR in the purchase of medications.

_____	_____	_____
Client Signature	Date	Witness

North Carolina
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MEMORANDUM

To: All Staff Assigned Volume I

From: Elizabeth W. Bishop – Section Chief, Program Policy, Planning and Evaluation

Date: February 20, 2007

Elizabeth W Bishop

Re: INTERIM POLICY AND PROCEDURE DIRECTIVE #03-2007
Morbid Obesity/Clinically Severe Obesity/Surgery for Clinically Severe Obesity

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Obesity is defined as an increase in body weight beyond the limitation of skeletal and physical requirements, as the result of an excessive accumulation of fat in the body. People with obesity are employed in most occupations and businesses. Being overweight or obese may cause little or no inconvenience to a person's career. However, when this condition reaches the extreme it may be diagnosed as morbid obesity or clinically severe obesity (used interchangeably) and may result in substantial impediments or even physical incapacitation.

Determination of Impairment

The diagnosis of morbid obesity should be provided, at a minimum, by a physician specializing in family practice, internal medicine, endocrinology or gastroenterology. The body mass index (BMI) is the standard in defining overweight, obesity, and morbid obesity. The BMI is calculated based on a person's height and weight – weight in kilograms (2.2 pounds per kilogram) divided by the square of height in meters (39.37 inches per meter). A BMI of 25 or more is considered overweight; 30 or more obese; and 40 or more, morbidly obese or clinically severe obesity. Generally, an individual having a diagnosis of morbid obesity with a BMI of 40 or more, and two or more co-morbid conditions would be considered as having a disabling condition for VR eligibility purposes. The most prevalent morbid obesity-related diseases include:

- Hypertension
- Diabetes

- Heart Disease
- Stroke
- Gastrointestinal Complications
- Osteoarthritis
- Sleep Apnea and Respiratory Problems
- Some Cancers

Determination of Impediments

The counselor must document how the morbid obesity is resulting in substantial impediments to employment. This documentation is accomplished through an analysis of the medical records along with other case data, such as the work history, educational/training history, and consultation with other specialists. Additionally, the medical data must evidence two or more of the following complications associated with morbid obesity:

- The presence of a primary diseases such as arteriosclerosis, diabetes, heart disease, hypertension, pseudo-tumor, etc., which is significantly complicated by morbid obesity. The individual would have restrictions normally associated with these types of medical conditions and made worse by the morbid obesity; i.e., fatigue, significantly diminished stamina and work tolerance, need for modified work schedule or frequent breaks, tendency to have shortness of breath.
- The obesity causes substantial orthopedic or physical limitations as documented by the medical history records including x-ray findings and other diagnostic test results. The ability to ambulate or carry-out physical tasks may be substantially impaired. Other limitations could include inability to utilize public transportation or utilize toilet facilities outside of the home.
- There is significant respiratory insufficiency or sleep apnea documented by respiratory function studies, blood gases, sleep studies, etc. Resulting impediments could include excessive daytime drowsiness and impaired alertness on the job, fatigability, tendency to have shortness of breath upon exertion.
- There is significant circulatory insufficiency documented by objective measurements. Resulting limitations could include impaired functioning of one or more extremities due to circulatory insufficiency.
- Skin disorders resulting in severe medical complications, pain and discomfort

VR Sponsorship of Medically Managed Weight Loss Programs

Medically managed weight-loss programs provide treatment in a clinical setting with a licensed healthcare professional, such as a medical doctor, nurse, registered dietitian and/or psychologist. These programs typically offer services such as nutrition education, physical activity and behavior modification/therapy. In some situations, closely related programs such as cardiac rehabilitation programs may be utilized to accomplish this purpose as they have many of the same essential components. Before VR will sponsor services for a client through a medically managed weight loss program, medical records must document that the individual has attempted other organized weight loss programs for a period of 9 months or more. VR may sponsor these programs for clients at the established Medicaid rate and subject to the individual meeting the Division's financial criteria. With regard to the duration of VR sponsorship, the guidelines in Policy Directive #5-2006 Physical Restoration and Physical Disabilities apply *(see under Guidelines for Anticipated Duration of Treatment).* Approval of extensions of VR sponsorship beyond 6 months may be approved by the

Unit Manager if the individual is demonstrating acceptable progress in their weight loss as evidenced by the progress reports from the program.

VR Sponsorship of Surgical Intervention

VR sponsorship of surgery for morbid obesity may be considered when it is determined to be a medical necessity by the appropriate specialist and when the following conditions are met:

1. the individual is at least 19 years old; **and**
2. medical record documentation substantiates that the individual:
    - has a BMI greater than or equal to 40 with serious complications/limitations in at least two of the following areas:
        - documentation of primary diseases such as arteriosclerosis, diabetes, heart disease, hypertension, pseudo-tumor cerebri, etc., is significantly complicated by clinically severe obesity
        - the obesity causes substantial orthopedic or physical impediments as documented by the medical history records including x-ray findings and other diagnostic test results
        - there is significant respiratory insufficiency or sleep apnea documented by respiratory function studies, blood gases, sleep studies
        - there is significant circulatory insufficiency documented by objective measurements; and
3. clinically severe obesity must be present for a period of at least three years; **and**
4. the individual must have made consistent efforts to lose weight over a period of 9 months or longer under physician supervision or in an organized weight loss program and failed; **and**
5. the individual has no correctable cause for the obesity, e.g.; an endocrine disorder; **and**
6. the surgery is one of the following procedures:
    - Gastric bypass, in which approximately 90% of the stomach is bypassed and anastomosed with the proximal jejunum (CPT code 43846, 43659 for laparoscopic procedure).
    - Vertical banded gastroplasty (also called vertical banded gastric partition or vertical gastric stapling) in which a proximal pouch of 30-60 mL and a one-centimeter outlet are created by a vertical row of staples and a horizontally placed reinforcing band (CPT code 43842, 43659 for laparoscopic procedure).

NC DVR does not sponsor procedures that are considered to be investigational:

- Jejunoileal bypass
- Biliopancreaticbypass
- Gastric wrapping
- Gastric banding
- Jejunocolostomy
- Mini-gastric bypass

Case Documentation Requirements - VR Sponsorship of Surgical Intervention for a Client

1. Documentation of a continuous nine month period or longer of all medical treatment modality therapies attempted by the individual under the supervision of a physician or in an

organized weight loss program to reduce weight, the duration of each therapy and the results of each treatment

2. Documentation of the individual's weight for each of the three previous years
3. The individual's present weight, height, skeletal frame, body mass index and gender
4. Medical history of the entire individual's diagnoses such as heart disease, pulmonary problems, arthritis, diabetes, etc.
5. Medical test results
6. Documentation that all correctable causes of obesity have been ruled out with test results of laboratory tests performed
7. Documentation of a psychological evaluation assessing the recipient's suitability for surgery and his/her ability to comply with lifelong dietary changes and medical follow-up. Components of such an assessment should include: levels of depression, eating behaviors, stress management, cognitive abilities, social functioning, self-esteem, personality factors or other mental health diagnoses that may affect treatment, readiness and ability to adhere to required lifestyle modifications and follow-up social support.
8. Documentation of a fully developed, 5-year psychosocial, nutritional, and activity- based follow-up plan.
9. Certification that the individual has been informed about all surgery risks, surgery sequelae, the need for extensive follow-up care, expectancy of weight loss and a signed statement that the individual has been informed of the risks and results and still desires a surgical procedure.
10. Description of the type of gastro-bariatric surgery planned and CPT code that describes the surgery planned.
11. VR may authorize follow-up surgeries if deemed to be medical necessities – ex: surgical skin flap removal. However, the Division cannot sponsor these type surgeries of they are purely elective.
12. The Division cannot authorize "up-front" administrative fees which are sometimes required by surgical clinics.

North Carolina
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MEMORANDUM

To: All Staff Assigned Volume I

From: Elizabeth Bishop, Section Chief for Program Policy, Planning and Evaluation

Date: May 2, 2007

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #04-2007**
Physical Restoration - SECTION 2-19 and Physical Conditions - SECTION 3-5

{This directive replaces Policy Directive #05-2006 dated 8/9/2005}

Physical restoration services may be provided to correct or significantly reduce a physical impairment[1] that is stable or slowly progressive and that results in substantial impediments to employment[2]. A slowly progressive condition is one in which the client's functional capacity is not expected to diminish so rapidly as to prevent successful completion of vocational rehabilitation services, and/or employment for a reasonable period of time. Physical restoration services are subject to the individual meeting the Division's financial needs criteria and comparable benefits, when available. This policy directive addresses both eligibility and service provision as they relate to physical impairments.

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[1] The Federal Rules and Regulations define a Physical impairment to mean - Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hematological and lymphatic, skin, and endocrine

[2] Substantial impediments to employment means that a physical or mental impairment (in light of attendant medical, psychological, vocational, educational, communication, and other related factors) hinders an individual from preparing for, entering into, engaging in, or retaining employment consistent with the individual's abilities and capabilities.

Temporary Medical Conditions Which are Not Eligible and Acute Treatment That Cannot Be Sponsored

Temporary conditions which are easily addressed and remedied with acute level treatment do not fall within the definition of impairment for eligibility purposes. Division funds should not be viewed and used strictly to supplant health insurance, or the lack thereof. There are medical conditions and services that many individuals face at some point in their lives that do not result in substantial impediments to employment. Examples of these types of conditions could include but are not limited to:

- Appendicitis
- Fractures
- Recent Onset Knee Injury
- Recent Onset Back Injury
- Recent Onset Hernia
- Recent Onset Gynecological Conditions
- Lipoma
- Cholecystitis (Gall Stones)
- Renal Calculus (Kidney Stone)

Eligibility for VR Services and Sponsorship of Physical Restoration Services

One or more of the following three guidelines may apply in making a determination of eligibility for VR services:

1. **Chronic Impairments** – Chronic generally refers to an impairment that has a long or indefinite duration, and is marked by frequent recurrences. There are, however, impairments which have a rapid onset, but by their nature, are chronic from the outset or early stage. These types of rapid onset impairments are covered under #3 below. Other chronic impairments have a gradual or insidious onset such as multiple sclerosis. In these situations, whether an individual has an impairment with substantial impediments to employment and/or whether the individual requires a program of Division services could be determined once the chronic nature of the impairment becomes evident. However, counselors must keep in mind that some chronic diagnoses, in the early stages, do not present substantial impediments or functional loss in the individual, so in these instances eligibility cannot be established. The existence of substantial impediments to employment may not be an issue until later stages of the disease. The medical data and the case history should provide the documentation of the chronic impairment, its current status and resulting substantial impediments.

   Examples of chronic impairments could include:
   a. Multiple Sclerosis
   b. Crohn's Disease
   c. Coronary Artery Disease
   d. Degenerative Joint Disease
   e. Hemophilia
   f. HIV Disease

g. Cerebral Palsy

In terms of the age of the medical data for determining VR eligibility, this depends upon the nature of the impairment in question. For example, HIV disease tends to be unstable with exacerbations and remissions – recent medical data would be needed to determine the current status of the diagnosis. However, cerebral palsy tends to be a stable, unchanging condition with a relatively fixed set of impediments, so older medical data may actually suffice for establishing the impairment, impediments and other components of VR eligibility.

2. **Acute or Temporary Medical Conditions/Injuries which Become Chronic** – To a certain degree, depending upon the diagnosis, the timeframe varies for an impairment transitioning from acute to chronic. Although most of the types of diagnoses covered above under temporary/acute conditions would not become chronic, some could progress into chronic impairments and present to VR as such.

   Examples could include:
   a. Back or knee impairments presenting functional loss that have been medically documented for extended periods of time.
   b. Fractured bone resulting in nonunion. (This impairment is defined to have occurred if the fracture site has failed to heal by six to nine months.)

   Often, the question of whether an acute or temporary condition has progressed to becoming chronic with substantial impediments can not be answered until the individual has undergone the initial set of medical interventions and had time to go beyond the acute phase in terms of recovery and healing (keeping in mind that physical therapy and other ancillary services are sometimes a part of the initial/acute interventions following surgery).

   However, if a diagnosis of an acute condition is documented by medical data and remains unresolved after 9 months it may be considered chronic. There may or may not have been optimal treatment interventions. The rehabilitation counselor must also establish from the medical data that the chronic impairment is presenting substantial impediments to employment.

   In exceptional situations, with counselor discretion, this determination may be made as early as six months from the initiation of medical intervention if the medical data definitively shows the existence of a chronic impairment. If the individual meets the other components of the VR eligibility criteria, then overall eligibility for the program may be considered. The analysis of the medical data by the counselor is of critical importance in making the determination of eligibility based upon a physical impairment.

3. **Injuries or Rapid Onset Impairments which have a High Probability of Becoming Chronic** – Some injuries or impairments, from the early stages, carry a high probability of becoming chronic, notwithstanding the acute level interventions that are initiated. In such cases, the distinctions between stable and unstable, acute and chronic may be unclear or academic. Also, the standards of six or nine months as indicators of chronic impairment (and stated above under number "2") may not be applicable in these cases. There may also be a

high probability of substantial impediments to employment resulting from the likelihood of chronic impairment. In these circumstances, though the Division still could not sponsor emergency interventions, counselor judgment is essential in determining on an individual case basis, at what point during the recovery process a chronic impairment with substantial impediments becomes apparent and Vocational Rehabilitation services would be appropriate. Examples could be:

a. amputations (either traumatic or disease connected)
b. strokes with resulting hemi-plegia or other functional loss
c. diabetes
d. seizure disorder
e. reconstructive surgery
f. spinal cord injury
g. traumatic brain injury
h. disfigurement of one or more limbs resulting from trauma or disease
i. second or third degree burns

Staffing with the Unit Manager, Quality Development Specialist and/or Unit Medical Consultant should occur whenever questions arise.

Physical Restoration as a "Substantial" Vocational Rehabilitation Service

VR sponsorship of a physical restoration service(s) would be viewed as a substantial service when it is:

1. provided to substantially reduce or eliminate limitations/impediments associated with a chronic impairment (consistent with the guidelines for criteria #1, #2, and #3 above in determining a chronic impairment), and
2. required by the individual in order to begin work, return to work, or maintain employment, and
3. provided within a supportive counseling and guidance relationship and/or in conjunction with other *Core* VR services.

The following are examples of supportive guidance and counseling interventions:

- *Helping the individual understand their diagnosis/impairment, impediments and what to expect during and after treatment*
- *Helping the individual understand the vocational implications of their diagnosis/impairment; i.e., need for part-time or modified duties following treatment, need for job re-assignment or job change because of impediments*
- *Career and educational guidance to help the individual select suitable jobs and/or type of training*
- *Assisting the individual in dealing with and adjusting to the emotional issues surrounding the diagnosis/impairment*
- *Referral to other community resources to assist with issues associated with physical restoration*

- *Liaison or interventions with medical providers to facilitate the individual's treatment, and medical needs*
- *Discussion and exploration of an individual's strengths, interests and abilities in relation to recommendations from the assessment data (medical and vocational) and other case information*
- *Providing supportive guidance and follow-up on specific impairment related issues after return to work*

Typically, two or more *Core* services (See 2-2-1 for listing of the *Core* services) are necessary to address an individual's rehabilitation needs. However, if only one *Core* service (e.g. physical restoration) is determined necessary, the supportive counseling and guidance provided by the rehabilitation counselor, or other Division support staff, and documentation of such becomes even more important. This supportive element distinguishes the VR service from that of simply serving a medical insurance function, or paying a medical bill. The presence of a *chronic impairment* and provision of the physical restoration service *within a VR guidance and counseling relationship* distinguishes this situation from those where VR would simply be *paying a bill* for an acute or otherwise temporary medical condition. The client need for the *guidance and counseling relationship* must be established as part of VR eligibility; specifically, in relation to the "*requires VR services*" component of the eligibility criteria.

Otherwise, if all that an individual requires is payment/sponsorship of a medical service, then the individual is not eligible for VR services. The counselor must always question whether the individual meets VR eligibility in *requiring a program of VR services* (meaning, are the skills, resources, and supportive counseling provided by a qualified VR counselor needed?). This does not apply to individuals who because of the nature of their disabilities require permanent assistive devices, rehabilitation technology, or ongoing on-the-job supports (examples – hearing aid, wheelchair, home or worksite modifications, etc.).

Secondary Restoration Issues Accompanying a Chronic Impairment

Please refer to **INTERIM POLICY AND PROCEDURE DIRECTIVE #05-2007** for policy guidelines on sponsorship.

Sponsorship of Medical Diagnostic Evaluations

Generally, the Division should not sponsor diagnostic medical evaluations of new onset impairments. The Division will not sponsor emergency hospitalization, diagnostics or treatment needed at the time of referral relating to an acute impairment, injury or suspected impairment. The appropriate point for VR involvement is generally the rehabilitation phase of chronic impairments. However, the Division may sponsor diagnostic examinations/assessments associated with stable or slowly progressive conditions for use in eligibility determination if available existing data containing a chronic diagnosis is insufficient in establishing a current impairment with impediments, or if an updated evaluation is advisable given the nature of the impairment. Examples could include situations in which the existing data obtained by the counselor is dated and insufficient in providing a current picture of client's condition or impediments; or, in which the condition may be unstable in nature, characterized by exacerbations and remissions, and an updated assessment is advisable to address the individual's current status and to clarify current impediments to employment.

An individual may present at referral with compelling indications of a chronic disabling condition even though there may be a lack of existing data. In this situation, in order to determine the existence of a disabling condition, the Unit Manager may approve an exception and authorize a diagnostic specialty evaluation. The Quality Development Specialist and/or Chief of Policy and Casework Operations should be consulted whenever questions exist. The counselor's knowledge base and professional discretion are critical factors in identifying the indicators of chronic versus acute, temporary or remediable conditions.

Guidelines Regarding Anticipated Duration of Medical Treatment

Some individuals have stable or slowly progressive conditions of long duration. The Division does not provide long-term or ongoing physical treatment. Accordingly, Division funds cannot be used to initiate treatment that is reasonably anticipated to last more than six months (per case) unless unit manager approval has been obtained. Agreed upon extensions may be approved only if the client maintains reasonable progress toward achieving the vocational goal. An exception can be when the purchase of medication/medical supplies is expected to exceed six months duration in support of training as a major service on the Individualized Plan for Employment. It is expected that the counselor would work jointly with the client to identify comparable benefits for long term medical care.

Guidelines Regarding the Planning and Sponsorship of Other Major VR Services in Conjunction with Physical Restoration

Individuals with chronic physical impairments that can be removed with little or no residual limitations will not be eligible for Division sponsored post-secondary training. However, if an impairment has hindered an individual in developing suitable work skills and work experiences, then VR post-secondary training services may be provided to address the need.

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MEMORANDUM **Updated by Interim Policy Directive #01-2009**

To: All Staff Assigned Volume I

From: Elizabeth Bishop, Section Chief for Program Policy, Planning and Evaluation

Elizabeth W Bishop

Date: August 10, 2007

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #07-2007**
Revisions to the Allowable Net Monthly Income Table (Based Upon Family Size) for the DVR-O116 Financial Needs Statement

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During the 2007 session of the NC General Assembly, increases were approved in the allowable net monthly income tables for establishing financial need among program clients and participants. Effective Monday August 13, 2007, the income limits based upon family size will increase to 125% of the Federal Health and Human Services poverty level. I have attached a table showing the *125% 2007 HHS Poverty Guidelines (Source: Federal Register, Vol. 72, No. 15, January 24, 2007, pp 3147-3148).*

The Financial Statement screen on CATS, section B, will be updated after close of business Friday August 10, 2007 with the new figures. If you have completed a Financial Statement on a consumer since July 1, 2007, you are not required to calculate the form using the new income limits. However, if the form has been completed after July 1, and the new income tables would positively impact the consumer meeting the financial needs criteria, then you may create a new form using the revised limits. The effective date of the new form you create will be August 11 or after.

If the amount authorized for a service would be revised based on the change in the financial needs criteria, the authorization can be adjusted prior to billing. Authorizations generated since July 1 can be adjusted as long as no payment has been previously made on it.

125% 2007 HHS Poverty Guidelines [1]

Persons in Family or Household	PER YEAR 48 Contiguous States and D.C. 125%	PER MONTH 48 Contiguous States and D.C. 125%
1	$ 12,763	$1,064
2	17,113	$1,426
3	21,463	$1,789
4	25,813	$2,151
5	30,163	$2,514
6	34,513	$2,876
7	38,863	$3,239
8	43,213	$3,601
For each additional person, add	4,350	$363

[1] **Rounded to the nearest dollar**

SOURCE: *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148

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OBSOLETE - EFFECTIVE 7/1/2013
Replaced by Interim Policy and Procedure Directive #2-2013

MEMORANDUM

To: All Staff Assigned Volume I

From: Elizabeth Bishop, Section Chief for Program Policy, Planning and Evaluation

Elizabeth W Bishop

Date: September 7, 2007

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #08-2007**
Revisions to SECTION 1-12 VR/IL Concurrent Records of Service for Personal Assistance Services

The purpose of this directive is to emphasize coordination and collaboration between the VR and IL programs in order to assure that VR participants are able to access the personal assistance service that is necessary to complete their rehabilitation program.

Case service authorizations may be issued by the IL counselor from RCC 1281 for personal assistance service (PAS) that are coordinated by the IL program and funded by the VR program based on the VR financial needs test once an individual has been determined eligible for VR services.

The following criteria and procedures will be used when the IL program is providing personal assistance services to VR participants that is funded by the VR program based on the VR financial needs test.

CRITERIA

The individual must be eligible for VR services and determined to be either SD or MSD with a

physical disability. The individual requires personal assistance services (PAS) in support of one or more of the CORE VR services planned on the Individualized Plan for Employment (IPE). For purposes of opening an IL case, the IL Counselor will utilize the eligibility determination made by VR as the basis for IL eligibility (in lieu of the standard IL eligibility decision) and development of the Individualized Plan for Independent Living (IPIL). The client/participant will have a dual VR/IL case with IL providing the personal assistance services for the individual. The funding for the PAS will come from VR case service funds. Personal assistance service is not subject to the financial needs criteria when provided to VR clients. The VR client may be the employer of their personal assistant or a home health vendor may be utilized to provide the personal assistance service. No IL funded services will be provided in these cases because all services will be coordinated and funded by the VR case.

The VR counselor will:

1. Determine that personal assistance service is required for the individual to complete their Individualized Plan for Employment (IPE).
2. Contact the IL Office to staff the case with the IL counselor covering that geographical area where the individual will be receiving the personal assistance service.
3. Notify the participant that personal assistance service will be coordinated by the IL program and that they will be contacted by the IL counselor.
4. Grant full CATS access for the VR case to the appropriate IL staff and provide copies of the VR eligibility decision, SD/MSD documentation, and supporting medical documentation.
5. Update the IPE to indicate that the personal assistance service is coordinated by the IL program and is funded by VR. The IPE should include the statement "Personal assistance service that is funded by VR, will be terminated when the VR case is closed."

The IL counselor will:

1. Take application

2. Determine eligibility using, to the extent possible, preliminary assessment data from the VR case file. The IL counselor will obtain from VR the:
   A) VR eligibility decision
   B) SD/MSD documentation
   C) Supporting medical documentation

3. Complete an IPIL outlining the services. Minimum jointly agreed upon services on the IL plan should include:
   A) Guidance and counseling provided by IL.
   B) Number of personal assistance service hours and rate of pay with VR Funded as Comparable benefit.
   C) Include the statement on the IPIL "Personal assistance service that is funded

by VR, will be terminated when the VR case is closed."

4. Issue the R2 for personal assistance service on the state fiscal year **from VR case using RCC 1281 / CS code T27**. The R2 is maintained in the IL case file until the case is closed.

5. Enter the VR information into the "Client Data Entry Screen" using the VR icon. The IL staff will key in the VR number, VR case load number, VR counselor code number, vender number, client ID number, select the IL office code, and the RCC 1281 will be filled in automatically. This information and the CS code T27 will print onto the case service invoice. The case service invoice should be printed on green paper for VR and the IL counselor will sign the case service invoice.

6. Keep the IL case open for the duration of IL coordinated personal assistance services.

7. All fiscal information (R2, case service invoices, timesheets, receipts for paying personal assistant(s) and federal/state taxes) must be maintained in the IL case file until the IL case is closed. At that time, a copy of this information will be provided to the VR counselor so that this information is maintained in the VR case, in keeping with the record retention schedule.

PROCESS TO TRANSITION VR CLIENTS RECEIVING PERSONAL ASSISTANCE SERVICES

In addition to the above procedures, for the VR participants currently receiving personal assistance service on the date of this interim Policy Directive; the VR counselor will continue to process the timesheets for payment until the IL counselor can open the IL case and develop the IPIL. The IL counselor will contact the VR counselor when the IPIL is developed. At that time, the VR counselor will provide the IL counselor with a copy of the following information, as part of the referral packet, if the participant is the employer of their personal assistant(s).

1. The federal and state employer ID number received from the VR participant.
2. The "State Unemployment Tax Rate" received from the participant in December 2006.
3. Form DVR-1021 "personal assistance services and reimbursement agreement."
4. Form(s) DVR-1022 "Personal Assistant Understanding of Employer Obligation to Withhold Social Security and Medicare Taxes (FICA)" for each personal assistant.
5. Form DVR-1022A "Payment of Federal Household Employer Tax for 2007."
6. Form(s) DVR-1019 "Record of Personal Assistance hours" and the case service invoice(s) for the pay periods 12/7/06 – 12/20/06 until the IL case is opened and IPIL is developed. The IL counselor will contact the VR counselor when the IPIL is developed.
7. Form(s) DVR-1019A "Personal Assistance Services Receipt" or Form(s) DVR-1019A-W "Personal Assistance Services Receipt Weekly Payment" for the pay periods 12/7/06 – 12/20/06 until the IL case is opened and IPIL is developed.
8. The case service invoice(s) for the first, second and third quarter SUTA and FICA taxes for 2007, if applicable.

9. Form(s) DVR-1022B "Payment of Federal/State Household Employer Taxes" for the first, second and third quarter SUTA and FICA taxes for 2007, if applicable.
10. The spread sheet that the VR counselor used to calculate the bi-weekly payroll for the pay periods 12/7/06 – 12/20/06 until the IL case is opened and the IPIL is developed.
11. The spread sheet that the VR counselor used to calculate the federal/state taxes (FICA, SUTA, FUTA) for the timeframe of 12/7/06 – 12/20/06 until the IL case is opened and the IPIL is developed.

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****OBSOLETE - EFFECTIVE 10/1/2011****
This policy has been incorporated into Volume VIII, under Section 2-16

MEMORANDUM

To: All Staff Assigned Volume I

From: Elizabeth W. Bishop – Section Chief of Program Policy, Planning and Evaluation

Date: February 14, 2008

Elizabeth W Bishop

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #01-2008**
Transportation - Revision to Rate for Sponsorship of Private Mileage

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When a private vehicle is used for transportation, the current IRS mileage rate (presently 50.5 cents per mile) will be authorized. This rate must be uniformly applied and is not open for negotiation with the client. The cost of transportation for a complete vocational rehabilitation program shall not exceed $12,000 *(also see Transportation – Volume V)*. Whenever it appears the maximum program rate ($12,000) will be exceeded, an exception should be requested to the Chief of Policy. In the future, the IRS mileage rate will be posted on Volume V and will be updated when revisions are made by the IRS *(see Transportation – Volume V)*.

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****OBSOLETE - EFFECTIVE 2/15/2016**
Replaced by Interim Policy and Procedure Directive #1-2016

MEMORANDUM

To: All Staff Assigned Volume I

From: Elizabeth W. Bishop – Section Chief for Program Policy, Planning and Evaluation

Elizabeth W Bishop

Date: October 2, 2009

Re: **INTERIM POLICY AND PROCEDURE DIRECTIVE #01-2009**
***Cross reference*: Interim Policy and Procedure Directive #07-2007**

The allowable net monthly family income has been increased to reflect 125% of the current Federal Poverty Level. In cases where an individual may benefit from the increase in the allowable monthly income amounts by now demonstrating financial need or by demonstrating a decrease in excess income, the DVR-0116 should be revised to reflect the Division's ability to contribute to a greater degree. Otherwise, there is no need to revise a client's DVR-0116 if the effective date precedes October 1, 2009.

The tables have been revised and were made effective in CATS on October 1, 2009. The new rates are as follows:

Allowable Net Monthly Income Table

Persons in Family/Household	125% Federal Poverty Level (Allowable Net Monthly Income Amount)
1	$1128
2	$1518
3	$1907
4	$2297
5	$2687
6	$3076
7	$3466
8	$3855
For each additional person, add	$390

North Carolina Department of Health and Human Services
Division of Vocational Rehabilitation Services
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****OBSOLETE** EFFECTIVE 6/1/2016**
Replaced by Policy Directive #3-2016

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy and Casework Operations

Date: September 18, 2012

Re: **Interim Policy and Procedure Directive #1-2012**

Displacement Prevention Partnership (DPP) as a Comparable Benefit

Background

In the Spring of 2012, the Division was notified by the NC Housing Finance Agency (NCHFA) of changes to the Displacement Prevention Partnership (DPP) funds. The program was previously funded by interest from the NC Housing Trust Fund; however NCHFA now has to access the principle meaning that different legislation applies. The Division was notified that recipients of the funds would be required to sign a promissory note and that DPP funds would be dispersed to qualified individuals as an unsecured loan. Recipients may qualify for up to $6,000 of DPP funds for accessibility modifications to their home. The loan will be forgiven at a rate of $2,000 per year until the balance is zero.

General Guidelines

- The Division has determined that DPP funds are a comparable benefit for IL home modification services. According to Division policies, **this comparable benefit must be accessed** for clients who require a home modification to increase his/her independence. The funds are reimbursed to the agency after the expense is incurred.
- If an individual resides in a qualifying home and meets DPP financial criteria, then **the individual must sign the DPP *Promissory Note*** agreeing to the terms of the DPP loan or the individual will not be considered for IL home modification services to be planned on the IPIL.

- A qualifying home includes permanent dwellings and mobile homes that do not have wheels. If the mobile home has wheels but has been placed on some sort of blocking or foundation, the home type should be staffed with the Housing and Transition Specialist located in the state office. Rental properties should also be staffed with the Housing and Transition Specialist when the home is owned by the client or a family member but located on rental property**.** Additionally, in order to be a qualifying home, the client must reside in the home and the home must be owned by the client or an immediate family member, or the client has a life estate in the property. An immediate family member is defined as a client's spouse, parent, sibling, child, grandparent, grandchild, aunt, uncle, or first cousin by either blood or marriage. Step and in-law relationships within these categories are also included.
- The DPP application is only valid for 90 days, with the opportunity to be extended for 180 days. Therefore, the modification process must be initiated timely once DPP funds are approved.
- In addition to IL clients, DPP funds should be utilized by clients with concurrent IL and VR cases when home modifications are required. In these situations, the 1281 budget should be utilized, and VR financial need policies apply.
- It is possible for a client's DPP application to be rejected. Possible reasons for DPP rejection are: (1) The client's previous expenditures from NCHFA programs have already met the $6000 maximum (e.g., previous expenses through Urgent Repair or Weatherization programs); (2) The client's household income exceeds the county-specific maximums or statewide non-metro maximums; (3) The client's home type does not meet the DPP criteria.
- There is a $6000 lifetime maximum per unit for NCHFA funding. This includes DPP funds and funds from NCHFA's other programs (e.g., Urgent Repair Program or Weatherization Program).

<u>Financial Guidelines</u>

- Any project requiring the expenditure of IL funds (non-reimbursed expenses) will be contingent on the availability of IL funds regardless of whether DPP funds can be accessed. (Volume VIII, Section 3-7-3) A $12,000 limit of the Division's State appropriated case expenditures per client per lifetime shall be placed on residence modification projects in general, with specific project limits based on the type of residence (currently $12,000 for a site built home and $8,500 for a mobile / manufactured home).
- Regardless of the funding blend of IL and/or DPP monies or other comparable benefits, when an individual project is estimated to cost above the specific type of modification limit, an exception must be approved by the Chief of Policy. The request for an exception applies to all situations including any potential third party contributions and shall be included in the total cost of the project being submitted for consideration by the Chief of Policy.
- When the Division receives reimbursement by a third party such as DPP, the amount of the third party contribution shall be deducted from the cost of the modification and the lifetime cap of $12,000 of the Division's State appropriated case expenditures per client.

- **If the IL financial needs test <u>is met</u>, and the DPP needs test <u>is met</u>**, the counselor proceeds in authorizing home modifications, with DPP reimbursing IL up to $6000 (depending on the cost of the modification). For projects estimated to cost more than the DPP maximum of $6000 (individual maximums could be less adjusting for previous expenses), IL may sponsor the excess depending on the availability of IL funds.
- **If the IL financial needs test <u>is not met</u> but the DPP needs test <u>is met</u>**, then the Division has approved extenuating circumstances allowing the IL counselor to authorize IL funds for the home modification project in the amount equivalent to the DPP loan approval amount; this is with the understanding that DPP will reimburse the Division these funds (up to DPP"s maximum of $6000). Essentially, the Division is waiving consideration and application of the client's excess resources towards the costs for the home modification project that DPP will reimburse to the Division. However, the client is required to contribute their excess resources (as recorded on the IL financial needs test) towards any sum that exceeds the DPP loan amount, **<u>unless</u>** arrangements have been made and documented on the needs test for the client to contribute their excess towards the cost of other required services on the IPIL. The counselor shall document these extenuating circumstances under the <u>Remarks – Extenuating Circumstances – Justification</u> section of the DVR-0116, *Financial Statement*. If there are excess resources that the client will need to contribute in excess of the DPP loan amount, the counselor must also document the manner in which the client will contribute the excess on the form.

<u>Process</u>

When a client applies for services and expresses interest in a home modification:

1. Determine the client's eligibility for services.
2. Engineer completes assessment when appropriate, generally in status 60.
3. Submit the DPP application to determine whether client qualifies for funding. Include projected amount of project based on engineer's assessment.
4. For **clients that meet the DPP criteria (up to their maximum of $6000 and adjusting for any previous expenditures through NCHFA programs),** prior to IPIL development, the counselor completes the DVR-0116, *Financial Statement*.
    - If the client **<u>does not meet IL financial need</u>**, the counselor records "DPP Waiver" under <u>Remarks – Extenuating Circumstances – Justification</u> on the *Financial Statement*. This allows the Division to authorize the funds (that will be reimbursed by DPP) without consideration and application of excess client resources. If there are remaining expenses for the modification above the DPP funding level, the Counselor must document on the *Financial Statement* the manner in which the client will contribute these funds, whether it be towards the additional home modification expenses (minus DPP reimbursement amount), or towards other required services to be planned in the IL program. If the client's excess is to be applied to the cost of the home modification, the client must pay the vendor directly prior to the work being initiated. The vendor should credit the client's payment on the invoice submitted to the Division.

- If there are no excess resources, then the modification project may be funded by DPP up to $6000 and the Division will cover the remaining expenses, pending the availability of IL funds.

5. For **<u>clients that do not meet the DPP criteria</u>**, the Division's existing IL policies regarding financial need apply.
6. The IPIL should be developed.
7. Bids are solicited for the project.
8. Request approval from Chief of Policy if bid exceeds agency project maximums.
9. Client signs the ***Promissory Note*** – prior to authorizing for project.
10. Follow existing IL policies for providing home modifications.
11. If the projected total cost of the modification project is greater than the actual total cost on the accepted bid, a ***DPP Modification Agreement*** form must be re-submitted with the actual cost and signed by the client.

    [If the projected cost is lower than the actual cost, then NCHFA will send an estoppel to the client with a copy to the Division's Housing and Transition Specialist, and no action is needed by the Division. Details about the Modification Agreement can be found on the Community Services link of the DVRS Intranet.]
12. The DVR-0116 *Financial Statement* may need to be recalculated if actual costs vary from the estimate.
13. When there are unusual or complicated financial situations, consult with the QDS or Manager for guidance on how to proceed.
14. The signed ***Request for Reimbursement,*** and original signed ***Promissory Note*** with W-9(s) for those listed on the note are submitted to the state office.

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****OBSOLETE -- EFF. 2/16/2015****
Replaced by Policy Directive #1-2015 - MFP Presumptive Eligibility

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy and Casework Operations

Date: September 18, 2012

Re: **Interim Policy and Procedure Directive #2-2012**

Money Follows the Person (MFP) and Deinstitutionalization

Background

Money Follows the Person (MFP) is a state demonstration project that supports Medicaid-eligible North Carolinians to have greater choice about where they receive long-term services and supports. It is funded by Medicaid through a partnership between North Carolina's Division of Medical Assistance (DMA) and the federal agency, the Centers for Medicare and Medicaid Services. MFP and DVRS began a formal partnership in 2010 to provide transition coordination and VR/IL services for qualified applicants. Participants who transition back into the community with MFP benefit from transition coordination, medical/personal services, assistance locating and acquiring accessible housing; and up to $3000 for transition related needs such as furniture, equipment, or accessibility modifications.

Guidelines for Reviewing the Referral

- MFP assists those residing in inpatient facilities (e.g. skilled nursing homes) for a minimum of 90 days to move into their own homes and communities with supports.
- MFP does not apply to individuals who wish to transition out of adult care homes. Any questions about the classification of a referral's facility can be directed to the Division's Housing and Transition Specialist.
- MFP transitions will only be coordinated for transitions which will occur within North Carolina.

- DVRS' Independent Living program has been identified as the MFP lead agency for individuals with physical disabilities who are under 65 years old. This means that these referrals will be directed to IL first. The Division will sometimes receive MFP referrals for individuals over 65 years old. In cases where, upon screening the referral, the primary issue resulting in institutionalization appears to be related to a mental health, intellectual, or developmental disability, the referral should be staffed with the Division's Housing and Transition Specialist.
- IL Eligibility criteria shall be applied to all MFP referrals. Ineligibility for IL Services does not imply ineligibility for MFP transition services by another lead agency. **MFP referrals that meet the IL eligibility criteria become cases with a goal of deinstitutionalization and are, therefore, top priority cases. According to Volume VIII, Section 3-7-3, counselors should process these priority applicants expeditiously.**

General Guidelines for Providing MFP Services

- MFP Transition Services is a service which may be provided by the IL program and is defined as those goods and services needed to support an individual in transitioning according to the MFP program guidelines.
- MFP Transition Services encompass many services traditionally provided by IL such as residence modification, equipment, assistive technology, and maintenance; however traditional service authorization maximums do not apply to MFP Transition Services. MFP Transition Services maximums are determined by the MFP budget.
- Regardless of the funding blend of IL and/or MFP monies or other comparable benefits, when an individual project is estimated to cost above the specific type of home modification limit, an exception must be approved by the Chief of Policy. The request for an exception applies to all situations including any potential third party contributions and shall be included in the total cost of the project being submitted for consideration by the Chief of Policy.
- Other policy requirements for traditional IL services which are a part of MFP Transition Services shall be followed (e.g., engineering requirements for residence modifications or guidelines for what comprises a furniture package).
- MFP Transition Services also encompass many services that are not traditionally sponsored by IL including, but not limited to extermination fees and payment of past due utility bills. MFP Transition Services shall NOT be used to purchase entertainment services such as televisions or cable hook-up.
- MFP Transition Services can be provided in status 60 if required to complete the comprehensive assessment (i.e., to assess the person's ability to transition). MFP services may be added to assist with rent deposits (either in status 60 or beyond). If the rent deposit is required to secure targeted

housing, the counselor may assist EVEN if MFP funding is not yet approved as long as transition coordination has been initiated. MFP will assume the deposit expenses EVEN if the client is not yet approved for transition or if the transition does not occur. Otherwise, MFP Transition Services should be provided once the client SECURES HOUSING.

Financial Guidelines and Comparable Benefits

- MFP Transition Services ARE subject to the IL financial needs test and comparable benefits. If an individual has excess resources as documented on the IL financial needs test, those resources must be applied first to the cost of planned services before transition services can be authorized. If the individual's resources are over and above the total estimated cost of the rehabilitation plan, including the costs associated with a transition, then the individual is not eligible for needs based services and should be referred to another lead agency for MFP transition coordination. IL may still provide non-cost services in these cases to assist the individual with the overall IL goal.
- Services that require expending IL funds are contingent on availability of IL funds regardless of whether MFP funds can be accessed.
- A $12,000 limit of the Division's State appropriated case expenditures per client per lifetime shall be placed on residence modification projects in general, with specific project limits based on the type of residence (currently $12,000 for a site built home, $8,500 for a mobile / manufactured home and $5,500 for a rented property).
- When the Division receives reimbursement by the third party, the amount of the third party contribution shall be deducted from the cost of the modification and the lifetime cap of $12,000 of the Division's State appropriated case expenditures per client.
- Comparable benefits apply for MFP Transition Services. Though not all MFP referrals will require CAP level of care, CAP-DA is considered to be a comparable benefit for MFP Transition Services. When an individual's CAP budget allows for CAP to contribute to transition services, these funds should be applied. The identification of CAP as a comparable benefit, however, should not delay MFP Transition service provision.
- CAP monies are not available until housing has been identified and the CAP plan-of-care approved.

Process

1. The Division's Housing and Transition Specialist receives the MFP referral.
2. The Housing and Transition Specialist notifies the field office of the referral and assigns a MFP Transition Coordinator.
3. The counselor contacts the referral for an IL screening. The goal of the screening is to:

- Determine whether the IL referral is appropriate (e.g., does the client have goals of independence, can they participate in the development of their own IL program?)
- Learn of individual's financial situation to determine if the individual is likely to meet IL financial needs criteria for MFP Transition Services (NOTE: MFP referrals should not be screened out just because the individual will not meet financial need. Non-cost services could be provided.)
- Assess housing to determine when housing is likely to be available.

4. Counselor notifies Housing and Transition Specialist of outcome of screening within 10 days of receipt of referral. If the individual is not an appropriate referral for IL, the counselor notifies the Housing and Transition Specialist so that a new lead agency can be identified.
5. If the individual is an appropriate IL referral, the counselor completes an IL application and eligibility process. If the counselor has questions about an applicant's eligibility for IL, or believes additional specialty data is needed for a determination, the counselor should make every effort to complete this process **within 30 days** of receipt of the referral.
6. MFP Transition Coordinator arranges for MFP initial staffing and invites the IL counselor.
7. Counselor determines financial need. If the client does not meet financial need, contact the Housing and Transition Specialist to discuss whether IL can assist with non-needs IL services or should client be referred to another lead agency for transition assistance.
8. If the client meets IL financial needs criteria, plan is developed and MFP Transition Services are included as appropriate.
9. The counselor should review required transition services with the Transition Coordinator whether these services will be required to complete the comprehensive assessment or are identified as a result of the comprehensive assessment. The Transition Coordinator can assist in confirming comparable benefits and identifying service providers. Once agreed upon and planned, MFP expenditures should be submitted to the Division's Housing and Transition Specialist for pre-approval prior to issuing the authorization. Once approved, the authorization can be issued.
10. The MFP Transition Coordinator develops the Transition Plan, and a copy of the plan is provided to the IL Counselor.
11. IPIL is developed to include MFP Transition Services based on the Transition Plan. MFP services are authorized and invoiced from the following budget:
    - RCC 2333: Transition Expenses up to $3000 (These expenses are funded 100% by MFP at the time the invoice is submitted based on the RCC.)

- All billing using the MFP RCC should be sent directly to the Housing and Transition Specialist who will review and then forward to fiscal services.

12. Communication should continue between the client, the IL counselor, and partnering agencies with the **Transition Coordinator** serving as the primary point of contact with the CAP/DA office and other members of the transition team.

North Carolina Department of Health and Human Services
Division of Vocational Rehabilitation Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Linda S. Harrington
Division Director

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy

Date: **February 25, 2013**

Re: **Interim Policy and Procedure Directive #1-2013: Staff Use of Social Media**

The purpose of this Directive is to address the use of Social Media and Social Networking Sites by Division staff, specifically communications with active consumers of the Division. This Directive was developed in accordance with the broader DHHS Policy on Social Networking/ Social Media Sites and with the Division's policy on Confidentiality of Client Information (Volume I and VIII).

This Directive is effective immediately.

- Employees are allowed to have personal social networking sites or interactive websites not maintained or located on a state-operated server. These sites must remain personal in nature and be used to share personal opinions and non-work related information. This helps ensure a distinction between personal and agency views. Employees must be certain that communications on any personal social networking sites do not interfere with their work during normal business hours. This excludes personal LinkedIn or similar networking tools for purposes of outreach to potential employers of the Division's consumers for purposes of basic contact not involving personal views or consumer-specific information.

- **Employees shall not use their personal social networking accounts to contact or communicate with consumers they are currently serving.** For situations in which staff have already made contacts with clients (or vice versa) on Facebook, twitter, MySpace, Google+ or others, these contacts shall cease with a brief communication by staff to the individuals explaining the termination. On Facebook this would involve "unfriending" or on Twitter "unfollowing".

- No confidential Division information shall be posted on any social media site.

- Employees should never use their state email account or password in conjunction with a personal social networking site.

- Email communications with consumers of the Division must be secure and confidential and generally must occur over state-operated servers and email networks.

- At this time, no Division unit office, section, region or staff member shall have any social media, or social networking site representing the Division.

- Division staff may utilize social networking sites to locate consumers by accessing the consumer's public Facebook or social network page to determine if contact information is available, much the same way a person would use a telephone directory to locate someone. However, staff must not attempt to contact consumers on Facebook. Social media access and use involving State equipment and resources are subject to the DHHS Computer Usage Policy at all times.

- DHHS has one official YouTube channel. No other YouTube channels are authorized. All work-related submissions for this channel must be approved by the DHHS Office of Public Affairs before posting and only after receiving approval through existing NC DVRS review and publication procedures.

- Personal views made and posted on YouTube shall not contain professional and agency views or information.

- Failure to observe and abide by this Directive may result in disciplinary action which may include dismissal.

North Carolina Department of Health and Human Services
Division of Vocational Rehabilitation Services

Pat McCrory
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Ambassador (Ret.)
Secretary DHHS

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy

Date: June 17, 2013

Re: **Interim Policy and Procedure Directive #2-2013:**
1281 Budget Suspension

Effective July 1, 2013 the 1281 budget will be suspended indefinitely. This directive provides clarification regarding procedures for handling 1281 authorizations currently in effect in concurrent IL/VR cases through July 1, 2013.

Effective immediately, no further services should be authorized using the 1281 budget. Services required for a primary vocational purpose should be authorized using VR funds (following VR policy). Likewise services required for a primary independent living purpose should be authorized using IL funds (following IL policy).

IL counselors in particular should be aware that they can no longer plan or provide services subject to financial need using VR financial criteria/policy to sponsor IL services (subject to financial need) with a primary independent living purpose. IL financial need must be established to provide services from IL funds.

All 1281 budget authorizations in current cases that are not expected to be paid by the last check write of the 2012-2013 state fiscal year (projected to be June 24, 2013) must be deleted and authorized using either the VR or IL counselor's case service budget – depending on whether the service is for VR or IL purposes as described above.

Current cases with outstanding authorizations in which the client does not meet the IL needs test (VR financial status used) but require an IL authorized service should be authorized by IL with documentation on a Progress Review explaining that these services were previously approved through utilization of the 1281 budget and will be honored by the IL program. No additional services subject to financial need should be authorized by IL unless the client meets the IL financial needs test.

NOTE – SPECIAL CIRCUMSTANCES PERTAINING TO PERSONAL ASSISTANCE SERVICES (PAS):
PAS currently authorized using the 1281 budget will remain in place and paid out of 1281 as currently authorized through the last GT Payroll Period of the current SFY which is June 16 – June 29. A new authorization for payroll period of June 30, 2013 – December 31, 2013 will be issued out of the regular VR case service budget until other funding sources are identified and/or the case can be served by IL for PAS.

North Carolina Department of Health and Human Services
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Pat McCrory
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****OBSOLETE - EFF. 8/1/2014****
This policy has been incorporated into Volume 8, Chapter 2; Section 2-3: IL Equipment

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy

Date: **April 24, 2014**

Re: **Interim Policy and Procedure Directive #1-2014: Durable Medical Equipment and Supplies for IL**

Definitions:

Durable Medical Equipment - Durable medical equipment (DME) is that which (a) can withstand repeated use;(b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of an illness or injury; and (d) is appropriate for use in the home. DME includes but is not limited to items such as manual and power wheelchairs, scooters, C-Pap equipment, stair-lifts, lift chairs, walkers and crutches.

Durable Medical Supplies – Durable medical supplies are non-durable supplies that (a) are disposable, consumable, and non-reusable in nature;(b) cannot withstand repeated use by more than one beneficiary;(c) are primarily and customarily used to serve a medical purpose;(d) are not useful to a beneficiary in the absence of illness or injury; and (e) are ordered or prescribed by a physician, physician's assistant, or nurse practitioner.

Emergency Purchase – A purchase that must be expedited when following the standard purchasing procedures would jeopardize the client's health, safety or impede the rehab process. There must be written justification in the case record to explain the circumstances. Counselors must consult with Purchasing staff before conducting an emergency purchase.

Preferred Vendor – After soliciting bids, the selection of a particular vendor when other vendors can provide the equipment at a lower cost. Written documentation justifying this request must be in the case record and must be included with the Service Justification Packet.

Service Justification Packet – Information required by the Chief of Policy and Purchasing staff in order to approve DME purchases and carry out purchasing procedures when applicable. The service justification packet is required when there is a request to:

- Purchase items that exceed local purchasing limits
- Waive Comparable benefits
- Purchase off the state term contract when the DME is available on the STC
- Purchase from a preferred vendor
- Sole source the purchase

The packet should include a narrative explanation of the request for purchase with verification and/or documentation to support the request. Medical records, equipment evaluation and specifications, prescription, vendor quotes, Financial Needs Survey with supporting verification and documentation of comparable benefits must also be included.

Sole Source/Competition Waiver – The selection of one vendor without following bidding procedures – waiving competition for the purchase of equipment. Written documentation substantially justifying this request must be in the case record and must be included in the Service Justification Packet. According to 01 NCAC 05B.1401 (NC Administrative Code), a waiver of competition can be considered if the purchase is under the agency's delegation and conditions permitting waiver are validated by the Purchasing Officer. Conditions permitting waiver-- subject to approval-- include situations where:

(a) performance or price competition is not available;
(b) a needed product or service is available from only one source of supply;
(c) emergency action is indicated;
(d) competition has been solicited but no satisfactory offers received;
(e) standardization or compatibility is the overriding consideration;
(f) a donation predicates the source of supply;
(g) personal or particular professional services are required;
(h) a particular medical product or service, or prosthetic appliance is needed;
(i) a product or service is needed for the blind or severely disabled and there are overriding considerations for its use;
(j) additional products or services are needed to complete an ongoing job or task;
(k) where products are bought for "over the counter" resale;
(l) where a particular product or service is desired for educational, training, experimental, developmental or research work;
(m) equipment is already installed, connected and in service, and it is determined advantageous to purchase it;
(n) where the amount of the purchase is too small to justify soliciting competition or where a purchase is being made and a satisfactory price is available from a previous contract;
(o) Where a used item(s) is available on short notice and subject to prior sale.

Procedures to Purchase Durable Medical Equipment (DME)

In order to purchase DME the counselor must establish the need for DME and obtain an evaluation for specifications. When purchasing wheelchairs, a Seating Evaluation should be obtained from an independent source, such as a wheelchair/seating clinic at a rehabilitation center/hospital. If no clinic is available or would result in significant delay, the counselor should use a state term contract provider, or other provider that has staff qualified with Assistive Technology Professional (ATP) Certification. This certification is administered by RESNA and a directory is available on their web site www.resna.org.

A prescription is required to purchase durable medical equipment and must be included with the authorization or purchase order and specifications to the vendor. State Term Contracts (STC) must be used for the purchase of DME when the required equipment is available through this

means (Department of Administration - Division of Purchase & Contract: (www.doa.state.nc.us). Counselors are required to check the State Term Contract for availability of needed equipment (The Division's Purchasing Section is available to help Counselors determine if a durable medical item is on STC). If the DME costs more than $500 the Equipment Security Agreement must be completed and filed in the case.

DME available on State Term Contract - Procedures

1. Obtain a quote from the STC vendor that lists the manufacturer's suggested retail price (MSRP) as documented on the manufacturer's order form when available or alternately the price quote obtained from the manufacturer; the percent discount applied to the MSRP; and the final price quote.

2. Add the service to the IL Service Plan. If additional approvals are required, this should be clearly stated on the IL Service Plan. Based on cost, the service will be classified according to three (3) thresholds.

    - ≤ $500 – No additional supervisor approvals required.
    - > $500 and < $10,000 – UM approval is required. If approved, proceed to step #3.
    - ≥$10,000 –Chief of Policy approval is required. The counselor shall assemble and submit a service justification packet to the Chief of Policy. If approved, proceed to step #3.

3. Once the planned service is approved (or the service is determined to be required as a part of the preliminary or IL needs assessment), field staff issues an authorization to the STC vendor at the contracted amount which includes shipping and delivery charges.

NOTE – if durable medical equipment is needed as part of the preliminary or IL needs assessment the same approval thresholds apply. Documentation in the case record should clearly indicate approval if required.

- If client has comparable benefits (Medicaid, Medicare, Private Health Insurance) the vendor must be informed at time of authorization and must file with the comparable benefit first. The vendor will receive an Explanation of Benefits (EOB) from the comparable benefit. If the EOB shows that the comparable benefit does not pay up to the contract amount for the item, the vendor can submit an invoice to the Division for the difference between the paid amount and the STC contract amount.
- If client does not have comparable benefits, then the vendor bills IL for full contracted amount.

DME not available on State Term Contract - Procedures

1. Verify that the item(s) are not available on the State Term Contract. Determine the estimated cost of the equipment.

2. For equipment estimated to cost ≤ $2500, the bid process should be completed by the counselor. The counselor should obtain a minimum of three (3) quotations as part of the bid process. Written quotes obtained from each of the vendors must include the MSRP as documented on the manufacturer's order form when available or alternately the price quote obtained from the manufacturer and the discounted price quote. The quotes must be maintained in the case record.

For equipment estimated to cost >$2500 a formal bid process will be completed by DVRS State Purchasing Section.

3. When the bids are received add the service to the IL Service Plan. This will classify the service according to three thresholds which determine whether additional approval is required. If additional approvals are required, this should be clearly stated on the IL Service Plan.

   <_ $500 – No additional supervisor approvals required.
   >$500-$2500 – UM approval is required. If approved, proceed to step #4.
   >$2500 Chief of Policy approval is required. The counselor shall assemble and submit a service justification packet to the Chief of Policy for approval. If approved proceed to step #4.

4. When the vendor has been selected through the bid process, the authorization shall be issued to the winning vendor for the bid amount. The individual (counselor or DVRS State Purchasing Section) that completed the bid process issues the authorization.

NOTE – if durable medical equipment is needed as part of the preliminary or IL needs assessment the same approval thresholds apply. Documentation in the case record should clearly indicate approval if required

Comparable Benefits

Comparable benefits must be utilized when available in the purchase of Durable Medical Equipment. Medicare, Medicaid, and/or private health insurance must be marked accordingly on the Division's case service authorization, unless in the "Less Resource Section" it has been ruled out with supporting documentation or the Chief of Policy has approved waiver of the benefits (see 3-11-3 Comparable Benefits). Additionally, see SECTION 1-17 Case Service Authorization, 1-11: Invoice Processing, for further instructions and procedures for purchasing and accounting for the comparable benefit.

Medicare:

Medicare recipients in select areas of NC will have special procedures and via CMS DMEPOS (Centers for Medicare Services CMS; Durable Medical Equipment, Prosthetics, Orthotics and Supplies). The select areas can be identified by CMS website [http://www.medicare.gov/supplierdirectory/search.html]. In these select areas, only CMS sanctioned providers (physicians and vendors) may be used for Medicare. For all

other areas of the state that are outside the CMS sanctioned provider areas, a vendor is selected that accepts Medicare following the procedures detailed above.

Clients having Medicare are expected to use their comparable benefit. In situations where the Counselor establishes that the client does not have the funds/resources to pay their Medicare copay, the Chief of Policy must approve an exception for the Division to waive or pay the Medicare copay.

Medicaid:
The Division cannot invoice for durable medical purchases when the client has Medicaid, and the needed durable medical equipment is approved for Medicaid purchase. The Division can consider sponsorship of non-covered components. The Chief of Policy must approve an exception for the Division to waive Medicaid.

Private Health Insurance
Clients having private health insurance are expected to utilize their comparable benefit. When a client's primary health insurance has approved a durable medical purchase and will be the primary payer, the Division may only consider sponsorship of non-covered components. In situations where the client is unable to access their private health insurance because of an inability to pay the deductible or copay, the Chief of Policy must approve an exception for the Division to waive the insurance, or pay the copay or deductible.

North Carolina Department of Health and Human Services
Division of Vocational Rehabilitation Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

****OBSOLETE EFF. 2/3/2015****
Issue has been resolved

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy

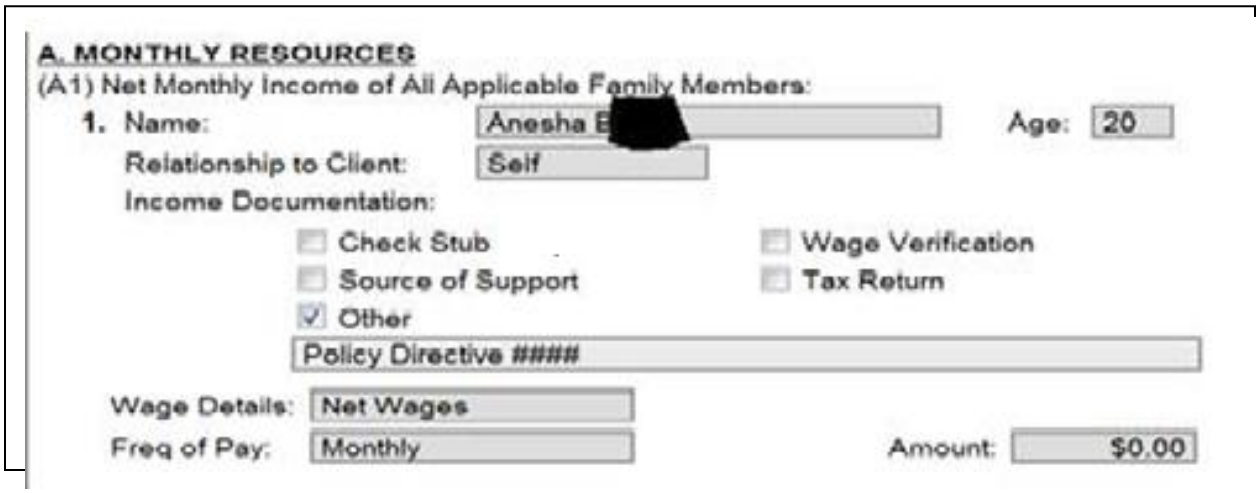
Date: June 30, 2014

Re: **Interim Policy and Procedure Directive #2-2014: Excess Income "Workaround" in BEAM**

BEAM functionality includes restrictions regarding how much users can authorize for a service based on the estimated Agency expenditure on the financial needs survey. In order to allow users to authorize for services when authorizations have been issued for the total IL contribution amount on the Financial Needs Survey the following procedures in this directive must be followed when the following Financial Needs Categories are selected:

Extenuating Circumstances
Excess Income Applied

1. Add the financial form to the electronic case in BEAM and complete it in an accurate (real) manner indicating that excess resources applied or extenuating circumstances is the financial needs category that applies to the client.
2. Print and sign the financial form.
3. Immediately add a new financial form to the electronic case file in BEAM where Section A1 is completed in the following manner:


A. MONTHLY RESOURCES
(A1) Net Monthly Income of All Applicable Family Members:
1. Name: Anesha E[redacted] Age: 20
Relationship to Client: Self
Income Documentation:
☐ Check Stub ☐ Wage Verification
☐ Source of Support ☐ Tax Return
☑ Other
Policy Directive ####
Wage Details: Net Wages
Freq of Pay: Monthly Amount: $0.00

Section F in this manner:

F. EXCESS RESOURCES

Excess Monthly Income		(C)	$0.00
X Appropriate Time Period			6 mos
Total Excess Resources	(C) x (3 or more months) =	(F1)	$0.00
Assets		(D)	$0.00
Contributions		(E)	$0.00
Total	(F1) + (D) + (E) =	(F)	$0.00

The number of months entered should be the same as that entered on the "real" financial. This will allow BEAM to accurately track the expiration date for the financial. Leaving this blank will result in a "shelf life" of 12 months for this financial as opposed to the intended time period recorded on the "real" financial (in this example 6 months).

Finally complete Section I in this manner:

I. FINANCIAL NEED CATEGORY

Yes, This individual meets the economic needs test (Section B)

4. Date and electronically sign the work around financial form.
5. Do not print or obtain signatures on the work around financial statement. This is an internal document, and should not be shared or discussed with the client.

North Carolina Department of Health and Human Services
Division of Vocational Rehabilitation Services

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Secretary DHHS

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy

Date: June 30, 2014

Re: **Interim Policy and Procedure Directive #3-2014:**
BEAM Service Structure and Service Selection

Background

In conjunction with implementing the Division's new BEAM case management system, client services will be re-labeled and categorized. Prior to BEAM implementation, the Division relied on two classification systems to manage services being planned, provided, and purchased for clients. On IL and VR plans, the Division used service labels that mostly corresponded with federal service types as required by the RSA-911 and RSA-704 reports. This resulted in 28 available service categories on the VR plan and 23 available service categories on the IL plan. There has been no service classification used for issuing authorizations. The Division used case service (CS) codes to classify services at the time of invoicing. There have been more than 75 unique case service codes used for categorizing invoices.

The Division's previous case management system enabled administrative users to roll-up the two separate service classifications to generate federal and state reports, but did not include controls to prevent the user from creating an authorization for a service that should be prohibited according to casework policy due to the client's status and/or whether or not the service had been previously approved on the client's plan. BEAM will, however, create an association between the client's plan and the authorizations that are generated for planned services. Therefore, rather than two disjointed classification systems, BEAM will utilize a single service classification system that will be used for selecting services on plans and authorizations as well as generating state and federal reports.

Standards for BEAM Service Classification

- **Services are labeled using familiar terminology specific to the needed service.** Attempts have been made to use labels that more specifically describe what service is being planned/authorized in order to clearly communicate with the client, representative, or vendor, to match terminology

used in casework policy, and to generate reports with consistent information. The intent is to remove some of the guesswork in determining how a service should be classified.

- **Services are associated with many automated controls that are maintained by the Division's BEAM system administrators.** The Division will use controls to determine the following:
    - how the service is federally reported
    - which account the service pulls money from when it is authorized
    - whether or not there are maximum rates or quantities
    - whether or not there are exceptions to maximum rates/quantities
    - which users are permitted to approve exceptions to service maximums
    - where in the system approval for exceptions are granted

  There are many other controls that may be maintained for services. Controls will be used to automate many of the Division's casework policies and approvals.
- **Services are added to plans and authorizations using a pick list.** This method assures uniformity and allows the system to run queries on the dollars spent on a service or the numbers of clients receiving a service. On plans and authorizations, users may add more detailed service information in free-text form beneath the selected service. This free-text information is not incorporated into reports or queries.
- **Some services are set up according to a "parent/child" hierarchy.** Some services have "child" services which inherit the basic qualities or controls of the parent service. "Child" services are generally sub- categories of a "parent" service and may have more stringent controls than the "parent" service. Once a client's plan has been approved by all required parties for a particular "parent" service to be provided by a specific vendor, then any of the "parent" service's "child" services can be authorized to the vendor. *Not all services will have "child" services. Also, if a service does have "child" services, the hierarchy of services currently only goes one level deep. (There are no "grandparent" relationships in service set-up).*

  Ex: Parent service: Assistive Technology Devices – Off Contract
  Child services: Adaptive Vocational Equipment
  Aids for Daily Living

- **A service is only connected to the vendors that provide the service.** The relationships between services and vendors are maintained by a DVRS BEAM system administrator. BEAM will not allow a user to plan a service or authorize a service to a vendor that does not provide the specific service.
- **Some services are duplicated in the system to represent qualities and controls that are *almost* identical, but not quite.** In general, only viable options should be available for selection based on qualities of the client or the user. However, users should take care to select the correct service as this will dictate rate maximums and approval flows that follow.

Ex: A user should take care when selecting “Assistive Technology Devices – **Off** Contract” versus “Assistive Technology Devices – On Contract as a service on the plan. **Selecting the correct service** will assure that State Office Policy and Purchasing are involved to approve and purchase the item if required.

BEAM Service Selection

Volume VIII casework policies apply when authorizing services for clients to access the application process, when authorizing services as part of the preliminary assessment, when planning and authorizing services as part of the IL needs assessment or IL Service Plan.

BEAM provides a mechanism for selecting services within authorization and plan forms that reduces the service pick list to only those options which are valid based on factors including the client’s program, status, and other client characteristics. The system’s methods of filtering out non-valid service options do not absolve the counselor of his/her responsibility to apply casework policies and practices otherwise stated in this manual to discern which services should be planned or authorized according to the client’s informed choice. The Division maintains its responsibility for planning and authorizing those services that are required to assist eligible individuals in planning for or achieving their independent living or employment goals.

A complete list of BEAM services available for DVRS users can be accessed by the BEAM PDQ, *View All DVRS Activated Services*.

North Carolina Department of Health and Human Services
Division of Vocational Rehabilitation Services

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Secretary DHHS

Elizabeth W. Bishop
Division Director

****OBSOLETE - EFFECTIVE 8/1/2018****
Replaced by Interim Policy and Procedure Directive #2-2018

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy

Date: **October 22, 2014**

Re: **Interim Policy and Procedure Directive #4-2014:**
Documents to be Signed and Retained in the Case Record

Until we have a completely paperless case management system, it will be necessary to maintain a hard copy case record. This policy directive identifies specific documents that must be printed and maintained in the hard copy case record. All documents that require a client/guardian signature must be printed in their entirety, signed by the client/guardian, and retained in the case record. There are other documents that must be printed and given to the client. For auditing purposes and consistency, these documents should also be copied for the case record.

Specific documents include:

- Agreement of Understanding/Application
- Release of Information Forms
- Eligibility Decision Letter
- Eligibility Decision Changes (i.e. addition of secondary impairment) – print or snapshot previous decision in BEAM
- SD Upgrade – print or snapshot previous decision in BEAM
- Financial Needs Survey - when client signature is required
- IPE/IL Service Plan
- Progress reviews
- Annual reviews

- Revisions
- Amendments
- Documents (email correspondence, memos) verifying approval external to BEAM. Examples include MFP, DPP, policy exceptions
- Documents created by a CIC, AUM that require approval by UM. Examples include status 26 closures, FNS with categories of excess income applied and extenuating circumstances.

It is not required to print and retain the following, but at the discretion of the counselor may be printed and retained in the case record:

- WRAP
- Authorizations
- Joint VR/IL Cases – not required to print concurrent documents

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****OBSOLETE: EFF: 8/15/2016****
Replaced by Policy Directive #4-2016

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy

Date: **February 16, 2015**

Re: **Interim Policy and Procedure Directive #1-2015:**
MFP Presumptive Eligibility

Background:
In order to more effectively utilize MFP resources and transition as many individuals as quickly as possible a new policy has been developed to expedite service delivery. While our previous policy worked well, and staff did a great job serving MFP eligible individuals, it is the priority of the Department to increase our ability to quickly and efficiently serve this population. The focus is to allow individuals to live independently if at all possible. If the transition is not successful, it is possible that traditional IL services might enable the individual to deinstitutionalize at some point in the future.

As always, successful transition requires close coordination and collaboration between the IL counselor and the MFP transition coordinator. For example, the IL Counselor and MFP Transition Coordinator should jointly develop the transition plan and build the transition budget. Please refer to the procedures for MFP transition for specific details on coordination of services at the end of this Directive for further details. This Policy Directive replaces Policy Directive #2-2012.

Effective immediately:
If an individual has been determined eligible for MFP the individual is presumed to be eligible for IL services. The MFP application and pre-transition checklist will suffice for verification of MFP eligibility. These documents must be maintained in the IL case record. Presumptive eligibility should be determined as quickly as possible, not to exceed 30 days from the date of the application. Medical records are not required to document the presumption of eligibility for IL. The counselor must gather medical records however, in order to plan services appropriately. If the MFP transition is not successful, these records will be critical to determine whether there are additional IL services that might assist with attaining a successful independent living outcome.

The IL Service Plan (ILSP) must be developed and implemented as quickly as possible. The development of the ILSP should not be delayed while awaiting approval for services. For example, while a home modification requiring approval by the COP is being reviewed, it is permissible to implement other services – such as the purchase of equipment, payment of rental deposits or furniture in order to expedite services overall.

Many MFP participants will require PAS as part of their transition plan. MFP participants have priority with CAP so they are not on a waiting list if deemed eligible by the CAP staff after their assessment. However, if they are in need of hours beyond what CAP can provide, then they become a priority on our PAS waiting list. If PAS services funded by IL are being considered as part of the transition plan, the IL counselor should consult with the Chief of Community Integration Services regarding the waiting list and availability of funds. If no IL funds are projected to be available the transition may be delayed.

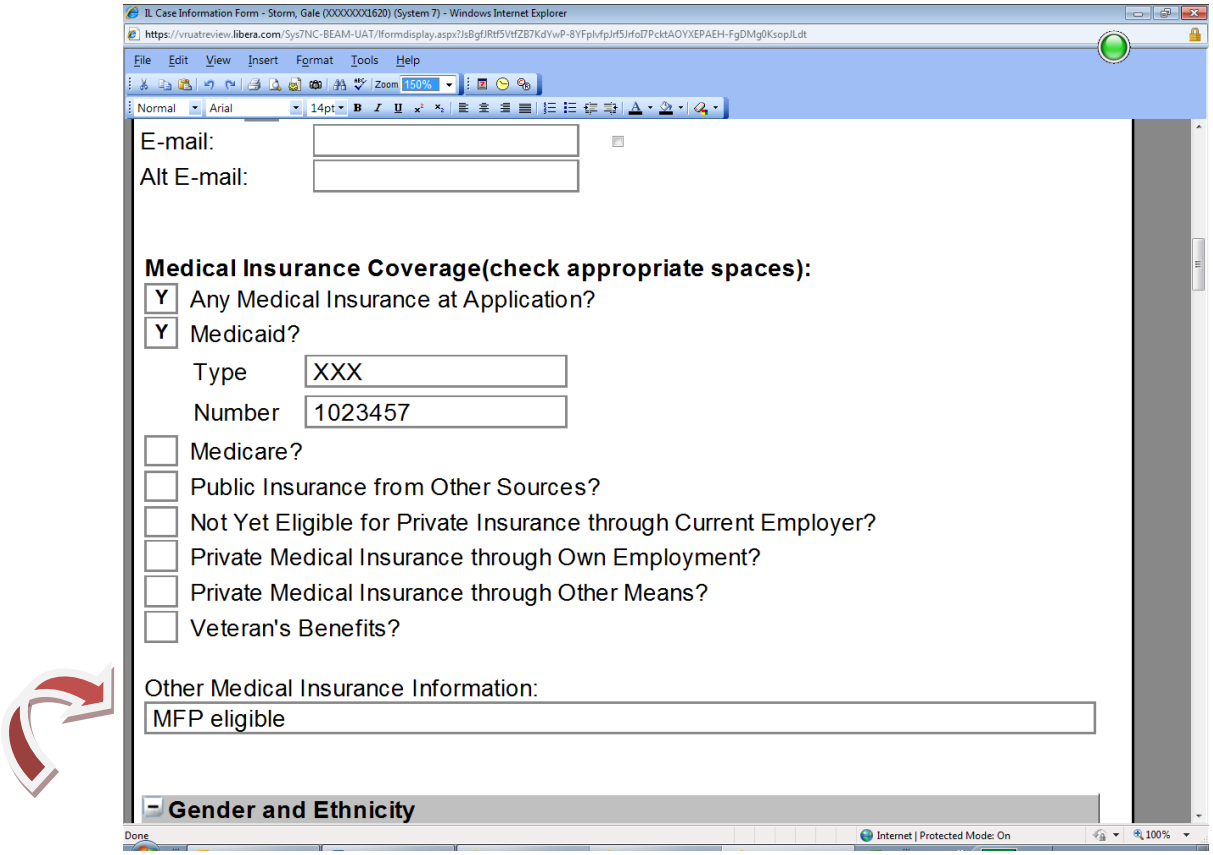
Financial need and comparable benefits must be considered for any services planned with MFP or IL funds. MFP funds generally cannot exceed $3000. In many cases both MFP and IL funds will need to be utilized. If additional services are required utilizing IL funds the counselor may provide these based on the MFP eligibility presumption and should not complete a separate IL eligibility decision.

<u>BEAM Workaround Procedures</u>:
Until programming changes are made in BEAM the following work around procedures must be followed:

MFP Presumptive Eligibility Documentation

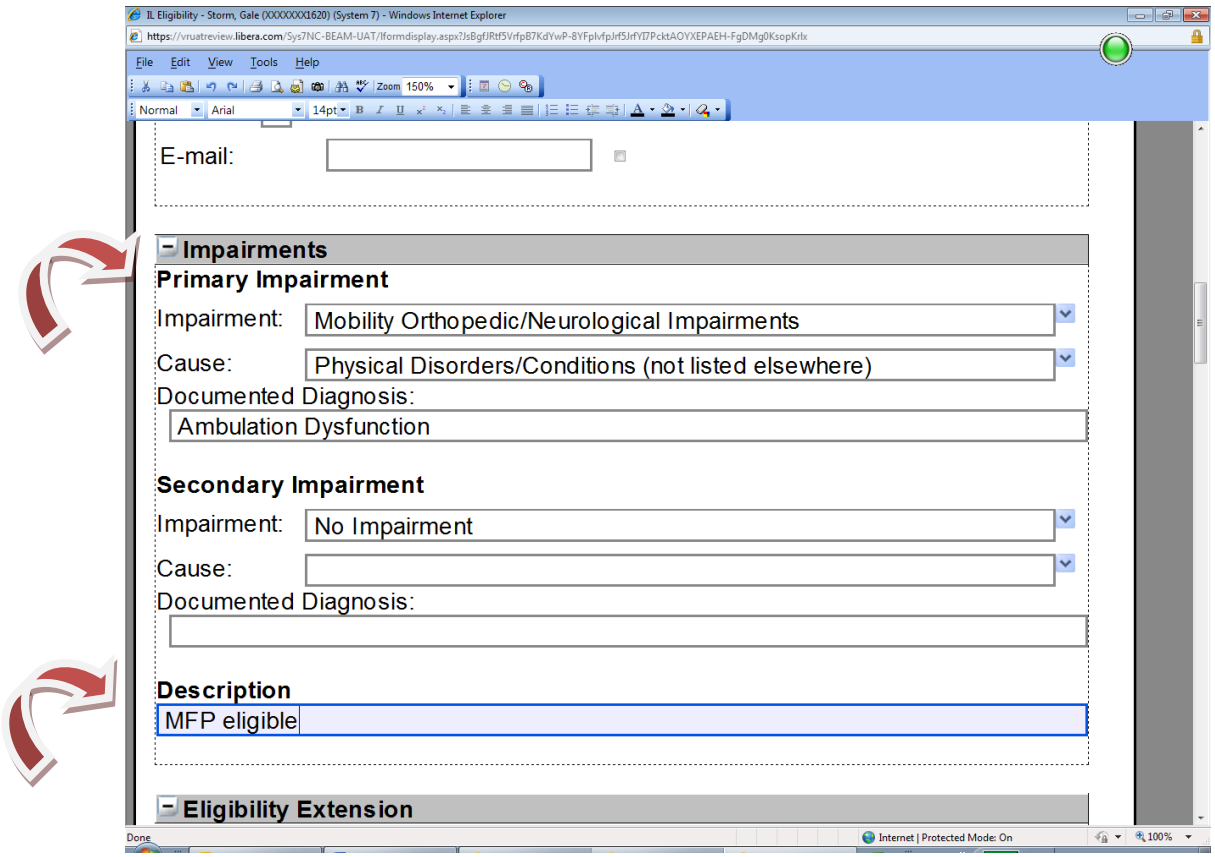
1. **Add the IL Eligibility Decision MFP letter to the ECF. This is a new eligibility letter that has been created to document presumptive MFP Eligibility. A copy of this letter must be sent to the client, and a copy kept in the case record.**

2. **Record on the IL Client Information Form (CIF) under Medical Insurance Coverage in the "Other Medical Insurance Information" dialog box: MFP eligible.**



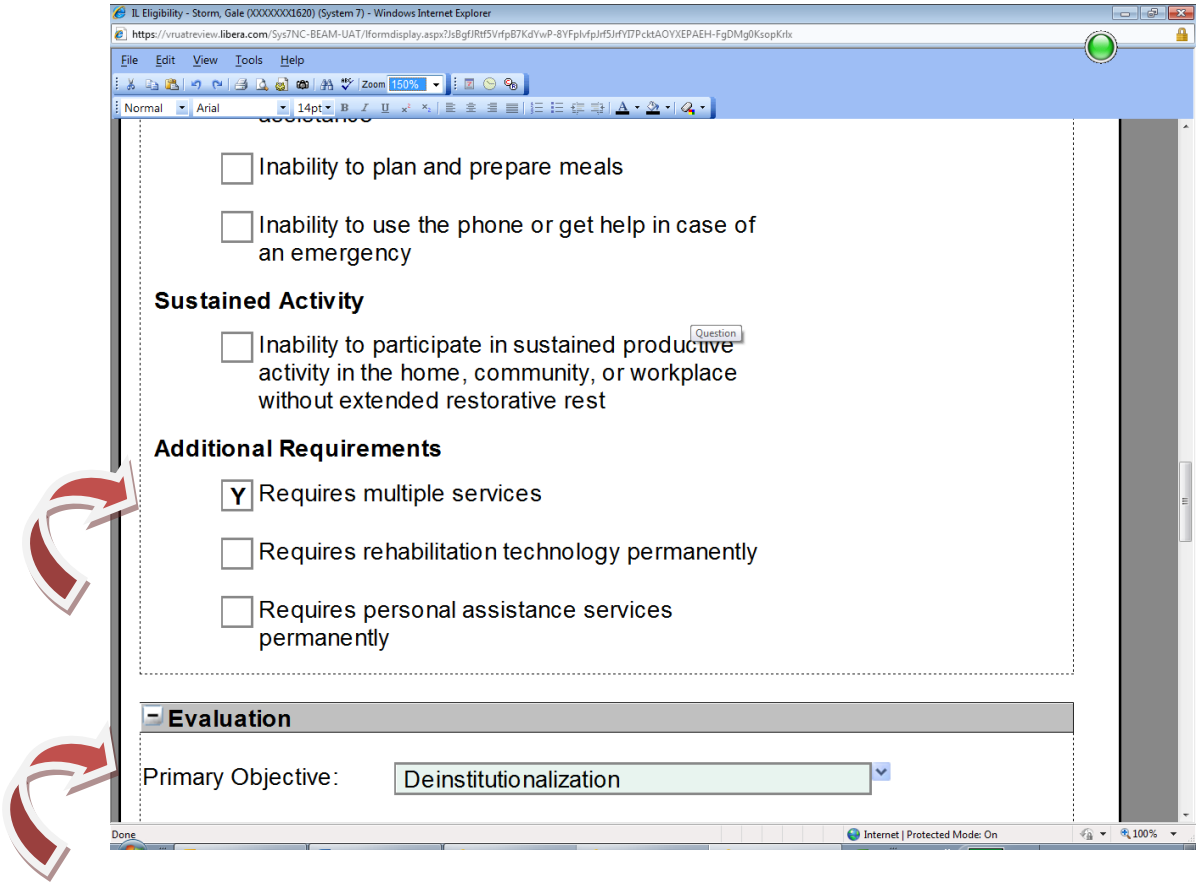
3. **Document on the IL Eligibility/SD Documentation the Primary Impairment and Functional Limitations based on the counselor's observation and knowledge of the client's impairment, with input from the client. The impairment and functional limitations can be updated, if needed, upon obtaining medical records.**

4. **Under Secondary Impairment in the <u>Description</u> dialog box (where counselors are currently supposed to be documenting SD Criteria): MFP eligible.**



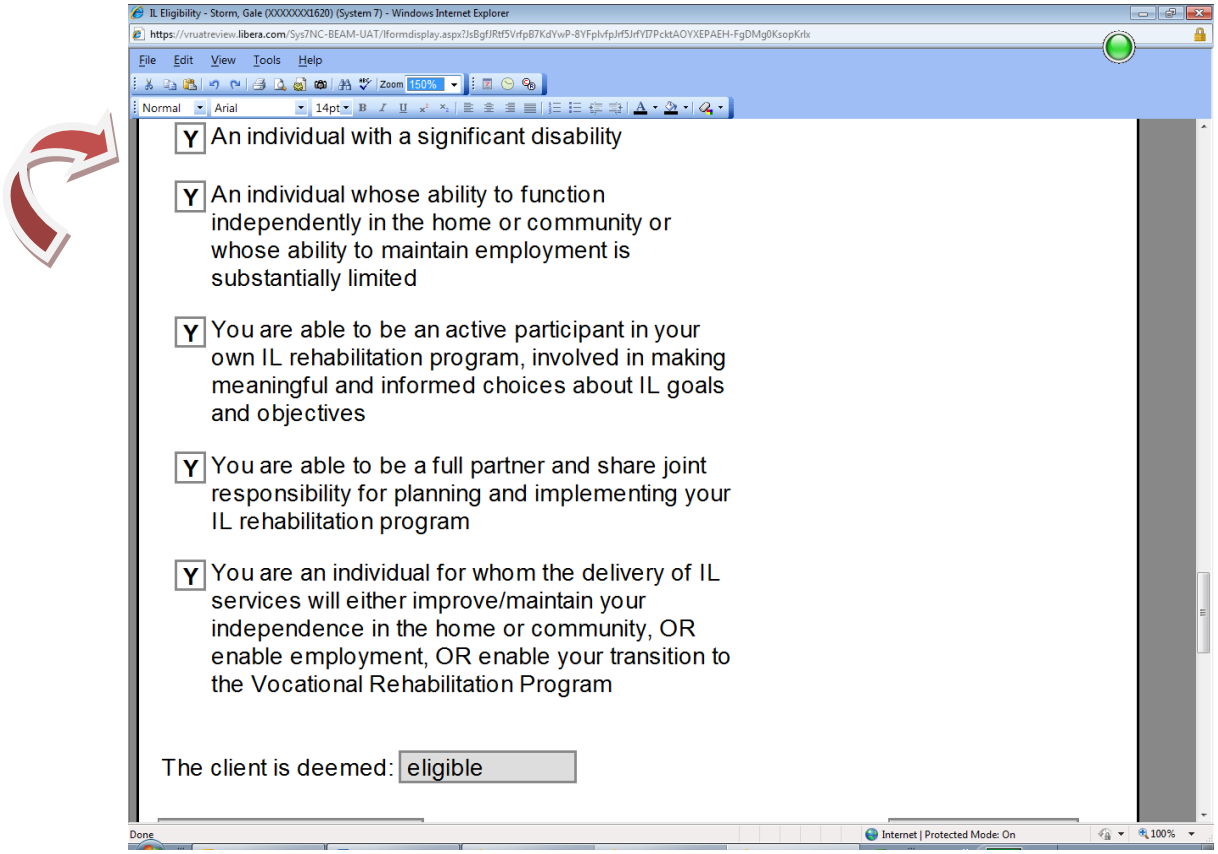
5. **Select “Requires multiple services” under the Additional Requirements section.**

6. **Select Primary Objective of “Deinstitutionalization”.**



7. **Complete the IL Goal/Detail section.**

8. **Select "Yes" for all remaining boxes to determine MFP presumption of eligibility.**



If the transition is not successful and the IL case is closed, closure code "Other" should be utilized. In the dialog box indicate "MFP transition unsuccessful" for the reason.

<u>General Guidelines and Procedures for Providing MFP Services</u>

- MFP Transition Services is a service which may be provided by the IL program and is defined as those goods and services needed to support an individual in transitioning according to the MFP program guidelines.
- Regardless of the funding blend of IL and/or MFP monies or other comparable benefits, when an individual project is estimated to cost above the specific type of home modification limit, an exception must be approved by the Chief of Policy. The request for an exception applies to all situations including any potential third party contributions and shall be included in the total cost of the project being submitted for consideration by the Chief of Policy.
- Other policy requirements for traditional IL services which are a part of MFP Transition Services shall be followed (e.g., engineering requirements for residence modifications or guidelines for what comprises a furniture package).

- MFP Transition Services also encompass many services that are not traditionally sponsored by IL including, but not limited to extermination fees and payment of past due utility bills. MFP Transition Services shall NOT be used to purchase entertainment services such as televisions or cable hookup.
- MFP Transition Services can be provided in status 10 if required to complete the comprehensive assessment (i.e., to assess the person's ability to transition). MFP services may be added to assist with rent deposits (either in status 10 or beyond). If the rent deposit is required to secure targeted housing, the counselor may assist EVEN if MFP funding is not yet approved as long as transition coordination has been initiated. MFP will assume the deposit expenses EVEN if the client is not yet approved for transition or if the transition does not occur. Otherwise, MFP Transition Services should be provided once the client secures housing.

Financial Guidelines and Comparable Benefits

- MFP Transition Services ARE subject to the IL financial needs test and comparable benefits. If an individual has excess resources as documented on the IL financial needs test, those resources must be applied first to the cost of planned services before transition services can be authorized. If the individual's resources are over and above the total estimated cost of the rehabilitation plan, including the costs associated with a transition, then the individual is not eligible for needs based services and should be referred to another lead agency for MFP transition coordination. IL may still provide services not subject to financial need in these cases to assist the individual with the overall IL goal.
- Services that require expending IL funds are contingent on availability of IL funds regardless of whether MFP funds can be accessed.
- A $12,000 limit of the Division's State appropriated case expenditures per client per lifetime shall be placed on residence modification projects in general, with specific project limits based on the type of residence (currently $12,000 for a site built home, $8,500 for a mobile / manufactured home and $5,500 for a rented property).
- When the Division receives reimbursement by the third party, the amount of the third party contribution shall be deducted from the cost of the modification and the lifetime cap of $12,000 of the Division's State appropriated case expenditures per client.
- Comparable benefits apply for MFP Transition Services. Though not all MFP referrals will require CAP level of care, CAP-DA is considered to be a comparable benefit for MFP Transition Services. When an individual's CAP budget allows for CAP to contribute to transition services, these funds should be applied. The identification of CAP as a comparable benefit, however, should not delay MFP Transition service provision.
- CAP monies are not available until housing has been identified and the CAP plan-of-care approved.

MFP Procedures

- The Division's Housing and Transition Specialist receives the MFP referral.
- The transition coordinator gives the MFP referral information to the IL counselor which must include the MFP application and Pre-Transition Checklist.
- The counselor contacts the referral and completes the IL application and presumptive eligibility process within 30 days of receiving the referral.
- The counselor determines financial need. If the client does not meet financial need, contact the Housing and Transition Specialist to discuss whether IL can assist with non-needs IL services or should client be referred to another lead agency for transition assistance. (NOTE: MFP referrals should not be screened out just because the individual will not meet financial need. Services not subject to financial need could be provided.)

- The counselor should review required transition services with the Transition Coordinator to determine whether these services will be required to complete the comprehensive assessment or are identified as a result of the comprehensive assessment.
- The MFP Transition Coordinator develops the Transition Plan, and a copy of the plan is provided to the IL Counselor.
- IL Service Plan is developed to include MFP Transition Services based on the Transition Plan. The Transition Coordinator can assist in confirming comparable benefits and identifying service providers. Authorizations in BEAM must be approved by the Housing and Transition Specialist.

North Carolina Department of Health and Human Services
Division of Vocational Rehabilitation Services

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Secretary DHHS

Claudia B. Horn, M.S.
Senior Director

Elizabeth W. Bishop
Division Director

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Neil Mac Britt – Chief of Policy

Date: **April 1, 2015**

Re: **Interim Policy and Procedure Directive #2-2015: Changes to Paper-Based Financial Needs Survey (FNS) and Completion of the Electronic FNS**

Due to revisions to the 1040 tax form by the IRS and changes to North Carolina income tax withholding percentages the paper version of the Financial Needs Survey worksheet, accessible via the agency intranet, has been updated.

Changes are limited to the tax worksheet portion of the form and include:

1. Change in the 1040 line used to determine gross federal tax withheld. This information was found on Line 61 of previous versions of the 1040. It is now appears on Line 63.
2. North Carolina income tax withholding was reduced from 7% to 5.8%. (Please see usage note below).

DVR has requested that Libera update the electronic version of the form in BEAM to reflect these changes. Until that development has been completed users should take the following action:

1. Enter information from Line 63 of the 1040 form despite BEAM's instructions to use Line 61

LINE 1 (Net Wages)

Calculate monthly net income using the 1040

Form 1040, line 7 (gross wages)

Form 1040, line 61 (gross federal tax w/h)

Calculate the state w/h tax (if return is not available) (use a rate of 7% of line 7)

Net annual wage income

divide by 12 (months)

Net monthly wages (calculated)

2. The state withholding calculation in BEAM is automated and users cannot edit the result. Until such time as Libera makes this correction continue to use the amount calculated at the old 7% rate. Please note this will NOT have a negative impact on the client's determination of financial need as the erroneous calculation resulting from use of the higher rate acts in favor of the client.

LINE 1 (Net Wages)

Calculate monthly net income using the 1040

Form 1040, line 7 (gross wages)

Form 1040, line 61 (gross federal tax w/h)

Calculate the state w/h tax (if return is not available) (use a rate of 7% of line 7)

Net annual wage income

divide by 12 (months)

Net monthly wages (calculated)

Usage Note: To avoid a discrepancy between the calculated result on the paper form and the calculated result in BEAM for NC withholding, users should continue to use the 7% when making the calculation until such time as the electronic form edits are complete.

Vocational Rehabilitation Services
HEALTH AND HUMAN SERVICES

CLAUDIA B. HORN
Senior Director

KENNETH W. GIBBS
Interim Division Director

Obsolete - Effective 3/1/2017
Replaced by Policy Directive #2-2017

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **February 2, 2016**

Re: **Interim Policy and Procedure Directive #1-2016: FNS Allowable Net Monthly Income Table**

Effective February 15, 2016

Increase in Allowed Net Monthly Income Amounts on Financial Needs Survey

Due to changes in federal poverty guidelines the following increases to Allowed Net Monthly Income will go into effect on February 15, 2016

Family Size	Poverty Guideline (100% Annual)	Poverty Guideline (125% Monthly)
1	11,880	1238
2	16,020	1669
3	20,160	2100
4	24,300	2531
5	28,440	2963
6	32,580	3394
7	36,730	3826
8	40,890	4259
> 8	+4,160	+433

The paper-based form, available on the agency Intranet, and the electronic form, in BEAM, have been updated accordingly. Those using the paper-based form in the field should verify that they have the latest version of the form. The following will appear at the top of the current paper-based form:

Financial Needs Survey Worksheet (effective 02/15/2016)

Vocational Rehabilitation Services
HEALTH AND HUMAN SERVICES

CLAUDIA B. HORN
Senior Director

KENNETH W. GIBBS
Interim Division Director

Obsolete - Effective 3/1/2017
Replaced by Policy Directive #1-2017

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **April 1, 2016**

Re: **Interim Policy and Procedure Directive #2-2016: Voter Registration**

Effective April 1, 2016

Voter Registration Policy

Background:
The National Voter Registration Act (NVRA) of 1993 was enacted to enhance voting opportunities for citizens, including individuals with disabilities who have historically low voter registration rates. NVRA requires that voter registration and the opportunity to update voter registration is made available to applicants and clients receiving services from designated State Agencies.

VR/IL staff are required to provide the same level of assistance in completing the Voter Registration Form as would be offered in the completion of other agency forms. It should be explained to the client that registering or declining to register to vote will not affect services provided by the Division. Agency staff must not seek to influence a client's political preference or party affiliation and must refrain from displaying campaign bumper stickers, wearing campaign or party buttons, pins etc. while conducting voter registration business.

Procedures:
VR/IL staff must make voter registration available and must complete a Voter Registration Preference form when the following occur:

- Application for VR/IL services
- Change of address
- Change of name
- Implementation of Post-Closure services

When assisting a client, the official question to ask discretely is ***"If you are not registered to vote where you live now, would you like to apply to register to vote here today?"***

The appropriate option should be selected on the Voter Registration Preference Form:

- YES, I would like to apply to register/preregister to vote here today
- YES, I would like to apply to register/preregister to vote, but I will take a voter registration application home to complete at a later time
- NO, I am declining the opportunity to register/preregister to vote today
- I am ALREADY REGISTERED to vote at my current address
- I am ALREADY REGISTERED but I would like to update my voter registration information. I will complete a voter registration Application/Update form for this purpose

The Voter Registration Preference Form should be signed and dated by the individual. The Spanish version of the Voter Registration Preference form is available on the NC State Board of Election website. If he/she refuses to complete this form the VR/IL staff should print the individual's name and date of birth, print and initial the form.

If the individual wishes to apply to vote or chooses to update his/her information they should be given the North Carolina Voter Registration Application Form. They may complete the form with VR/IL assistance, or may choose to take the form to complete at a later time. These forms need to be requested through the NC State Board of Elections and an adequate supply is to be on hand at every location clients are served. It is imperative that all forms used by the Division to be coded with the agency code "02" at the top so that it can be tracked appropriately.

Each unit office shall have a designated NVRA site coordinator who is responsible for sending newly completed, updated Voter Registration forms and the Voter Registration Preference forms to the appropriate county Board of Elections within five workdays. In turn, each satellite office will have a designated NVRA coordinator who is responsible for collecting and sending newly completed, updated Voter Registration forms and the Voter Registration Preference forms to the unit office designated coordinator.

In order to reduce mailing expenses and improving tracking, site coordinators are strongly encouraged to utilize the electronic reporting portal available through the NC State Board of Election website to regularly enter the information from the Voter Registration Preference Forms. If the electronic portal is used, then only completed Voter Registration forms (in contrast to Voter Registration Preference Forms) need to be mailed/delivered to the respective county board of elections.

Retention of records

Copies of all mailed or faxed transmittals submitted to the county Boards of Elections shall be retained in the respective unit/satellite offices for a period of 2 years for auditing purposes. No copies of completed Voter Registration forms shall be retained.
All submissions via the electronic portal shall be documented and initialed as entered (via the portal) on the corresponding transmittal forms that are then retained for the 2 year period.

Reporting of data

When a consumer responds to the Voter Registration Preference Form, it is important for the electronic version in BEAM to be signed and retained in the system for our internal reporting purposes. The State Board of Elections NVRA section has also agreed to provide the Division regular reports that should reflect the number of Voter Registration Preference Forms submitted via the NVRA electronic portal and those submitted to each county board of elections. For increased accuracy, it is strongly encouraged to use the electronic portal to submit Preference Form information.

Resources

NC State Board of Elections:
website: http://www.ncsbe.gov/Elections/NVRA
Phone: 1-866-522-4723

[52 U.S.C. § 20501 - 52 U.S.C. § 20511; NCGS §163-82.20]

Vocational Rehabilitation Services
HEALTH AND HUMAN SERVICES

CLAUDIA B. HORN
Senior Director

KENNETH W. GIBBS
Interim Division Director

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **May 16, 2016**

Re: **Interim Policy and Procedure Directive #3-2016: Displacement Prevention Partnership (DPP) as a Comparable Benefit**

Effective June 1, 2016

Background

In the Spring of 2012, the Division was notified by the NC Housing Finance Agency (NCHFA) of changes to the Displacement Prevention Partnership (DPP) funds. The program was previously funded by interest from the NC Housing Trust Fund; however NCHFA now has to access the principle meaning that different legislation applies. The Division was notified that recipients of the funds would be required to sign a promissory note, submit a W9 and that DPP funds would be dispersed to qualified individuals as an unsecured loan. Recipients may qualify for the maximum amount allowed as determined by NCHFA for accessibility modifications to their home. The **loan** will be forgiven at a rate of $2,000 per year.

General Guidelines

- The Division has determined that DPP funds are a comparable benefit for IL residence modification services. According to Division policies, this comparable benefit must be accessed for clients who require a residence modification to increase their independence. For clients who are utilizing both MFP and DPP funding, MFP funding must be exhausted to capacity prior to utilizing DPP funds. The funds are reimbursed to the Division after the expense is incurred.
- Qualifying homes include permanent dwellings and mobile homes that do not have wheels. If the mobile home has wheels but has been placed on some sort of blocking or foundation, the home type should be staffed with the State Office DPP Representative.
- When the client has a concurrent record of service for IL and VR with a residence modification as a planned service, refer to the policy guidelines in Volume VIII-Section 1-13: Concurrent Records of Service for instruction.
- Refer to Volume VIII- Appendix: Residence Modification Guidelines regarding repairs.

Financial Guidelines

- Any project requiring the expenditure of IL funds (non-reimbursed expenses) will be contingent on the availability of IL funds regardless of whether DPP funds can be accessed. (Volume VIII, Section 3-7-3) A $12,000 limit of the Division's State appropriated case expenditures per client per lifetime shall be placed on residence modification projects in general, with specific project limits based on the type of residence (currently $12,000 for a site built home and $8,500 for a mobile / manufactured home).
- Regardless of the funding blend of IL and/or DPP monies or other comparable benefits, when an individual project is estimated to cost above the specific type of modification limit, an exception must be approved by the **Chief of Policy.** The request for an exception applies to all situations including any potential third party contributions and shall be included in the total cost of the project being submitted for consideration by the Chief of Policy.
- When the Division receives reimbursement by a third party such as DPP, the amount of the third party contribution shall be deducted from the cost of the modification and the lifetime cap of $12,000 of the Division's State appropriated case expenditures per client.
- **If the IL financial needs test <u>is met,</u> and the DPP needs test <u>is met</u>,** the Counselor proceeds in authorizing residence modifications, with DPP reimbursing IL up to NCHFA allowable maximum. For projects estimated to cost more than the DPP allowable maximum, IL may sponsor the excess depending on the availability of IL funds.
    - If there are no excess resources, then the modification project may be funded by DPP up to the maximum amount allowed by NCHFA and the Division will cover the remaining expenses, if the client meets the financial needs test and if the funds are available.

  Please note: If the client's previous expenditures from NCHFA programs have already met the current maximum NCHFA allowance (e.g., previous expenses through Urgent Repair Program), the client will not be eligible for DPP funds. **If the** maximum NCHFA allowance is increased, the client may be eligible for additional DPP funds.

- **If the IL financial needs test <u>is not met</u> but the DPP needs test <u>is met,</u>** the Division has approved extenuating circumstances allowing the IL counselor to authorize IL funds for the residence modification project in the amount equivalent to the DPP loan approval amount with the understanding that NCHFA will reimburse the Division these funds. Essentially, the Division is waiving consideration and application of the client's excess resources towards the costs for the residence modification project that NCHFA will reimburse to the Division. However, the client is required to contribute their excess resources (as recorded on the IL Financial Needs Survey) towards any sum that exceeds the DPP loan amount, <u>unless</u> arrangements have been made and documented on the Financial Needs Survey for the client to contribute their excess towards the cost of other required services on the Independent Living Service Plan (ILSP). The counselor shall document "DPP Waiver" for these extenuating circumstances under the <u>Remarks - Extenuating Circumstances - Justification</u> section of Financial Needs Survey (FNS). If there are excess resources that the client will need to contribute in excess of the DPP loan amount, the counselor must also document the manner in which the client will contribute the excess on the FNS form. If the excess is to be applied to the cost of the residence modification, the client must pay the vendor directly prior to the work being initiated. The vendor should credit the client's payment on the invoice submitted to the Division.

  Please note: *When there are unusual or complicated financial situations, consult with the Unit Manager or QDS for guidance on how to proceed.

Process

Please note: *Follow existing IL policies for providing residence modifications.*

If at any point in the process the client does not meet the qualifications for DPP, the documentation must be reflected in the case notes.

When a client is determined eligible for IL services and is in need of a residence modification:

A. Engineer completes assessment when appropriate.

   Please note: *The projected amount of the project is based on engineer's assessment or applicable quotes.*

B. Determine the client's eligibility for DPP funding:

   The DPP Excel Workbook, the Promissory Note and the Life Estate template are located on the I-drive to be used in the DPP Process.

   1. Verify ownership of the property. If verification cannot be located, this will need to be discussed with the owner(s) to involve them in locating documentation to substantiate ownership.

   2. If the client is the owner**,** all owner(s) must sign the DPP application form. Please inform the owner(s) they will need to sign a promissory note and W9.

      Please Note: *If the client is the owner and refuses to sign the DPP documents, the client is ineligible for DPP funding. Since DPP is a comparable benefit the modifications cannot be provided using IL funds unless a policy exception is granted.*

   3. If the client is not the owner or married to the owner, the owner(s) must sign the DPP application form and provide a signed, notarized Life Estate.

   4. List all occupants of the home (related or not related to one another) under Household Membership. If the owner(s) does not reside in the home, include them on household membership but indicate that they don't live in the home.

   5. Verify Income for all persons living in the household including children and non-family members.

   6. DPP application form, loan reservation form, approved forms of verification of home ownership and the Life Estate, if applicable are submitted to the DPP Representative.

   7. When approved or denied an email notification will be sent by DPP Representative to the person designated as the contact person indicating the amount reserved and the due date. The project is to be completed in **90 days**.

      a. Do not start or add to the project without prior approval from the DPP Representative.

b. If there are extenuating circumstances and the project is expected to go over 90 days, the contact person sends an email to the DPP Representative to request an extension including the reason for the delay and expected time of completion. A returned response will be sent if NCHFA approves or denies the extension.
c. If the projected total cost of the modification project is greater than $500 over the Loan Reservation amount, a request for increase must be sent to the DPP Representative.
d. If there are any changes or errors on the Promissory note, the form must be correct and re-signed by the homeowner(s).

C. Reimbursement - Once the work is completed, the signed Request for Reimbursement, and signed Promissory Note with original signature(s), W-9(s) and invoicing paperwork are submitted to the DPP Representative.

D. For clients that do not meet the DPP criteria, the Division's existing IL policies regarding financial need apply.

Vocational Rehabilitation Services
HEALTH AND HUMAN SERVICES

CLAUDIA B. HORN
Senior Director

TARA K. MYERS
Division Director

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **August 1, 2016**

Re: **Interim Policy and Procedure Directive #4-2016: Money Follows the Person (MFP) Presumptive Eligibility**

Effective: August 15, 2016

This Policy and Procedure Directive replaces Policy and Procedure Directive #1-2015.

The intent of MFP Presumptive Eligibility is to ensure that service provision occur in a manner that is efficient and timely. MFP is a federally funded demonstration project that supports individuals living in a skilled nursing facility who can, with supports, reside in their own residence. A comprehensive system of community-based services and supports are available through the NC Medicaid for Long-Term Care waiver programs, including the Community Alternative Program (CAP) or the Program for All-Inclusive Care (PACE). An array of services including in-home aides, rental assistance, and prioritization for affordable and accessible targeted housing units are available through the waiver programs and family/caregiver/community supports are coordinated by a transition team.

Federal timelines and expectations differ from the IL program guidelines so it is imperative that full priority be granted and eligibility be presumed. There is recognition that not every referral is appropriate and not every transition will be long term. Full emphasis must be on attempting a successful transition. The ultimate decision rests with the IL Counselor to determine, after presumptive eligibility efforts, if the IL case will remain active.

The focus is to allow individuals to live independently if at all possible. If the transition is not successful, it is possible that traditional IL services might enable the individual to deinstitutionalize at some point in the future. As always, successful transition requires close coordination and collaboration between the IL counselor and the MFP Transition Coordinator. For example, the IL Counselor and MFP Transition Coordinator should jointly develop the transition plan and build the transition budget once it has been determined that the transition is viable. Please refer to the procedures for MFP transition for specific details on coordination of services at the end of this Directive.

MFP Presumptive Eligibility

An individual is determined eligible for MFP by the Division of Medical Assistance (DMA) based on the following criteria:

- The individual has been in a skilled nursing facility or acute care facility for 90 days
- The individual is Medicaid eligible at a minimum of one day prior to discharge and is eligible for community and home-based services

If the above criteria are met, the individual is presumed to be eligible for IL services. The MFP Application and Pre-Transition Checklist will suffice for verification of MFP eligibility. These documents must be maintained in the IL case record. Presumptive eligibility should be determined as quickly as possible, not to exceed 30 days from the date the MFP application is received by the IL counselor. Medical records are not required to document the presumption of eligibility for IL. However, the counselor must gather medical records in order to plan services appropriately. If the MFP transition is not successful, these records will be critical to determine whether there are additional IL services that might assist with attaining a successful independent living outcome.

General Guidelines and Procedures for Providing MFP Services

- MFP Transition Services are services which may be provided by the IL program and are defined as those goods and services needed to support an individual in transitioning according to the MFP program guidelines. MFP Transition Services encompass many services that are not traditionally sponsored by IL including, but not limited to groceries, household goods, extermination fees, and payment of past due utility bills. MFP transition services shall NOT be used to purchase entertainment services such as televisions and cable services.
- MFP Transition Services can be provided in status 10 if required to complete the comprehensive assessment (i.e., to assess the person's ability to transition) or to assist with rent deposits if required to secure targeted housing. The counselor may assist with rent deposits even if MFP funding is not yet approved as long as transition coordination has been initiated. MFP will assume the deposit expenses even if the client is not yet approved for transition or if the transition does not occur. Otherwise, MFP Transition Services should be provided once the client secures housing.
- Other policy requirements for traditional IL services which are part of MFP Transition Services shall be followed (e.g., engineering requirements and required approvals for residence modifications or guidelines for what comprises a furniture package).
- Many MFP participants will require Personal Assistance Services (PAS) as part of their transition plan. MFP participants have priority with the Community Alternatives Program (CAP) so they are not on a waiting list if deemed eligible by the CAP staff after their assessment. However, if they are in need of hours beyond what CAP can provide, then they become a priority ONE on the DVR PAS waiting list. If PAS services funded by IL are being considered as part of the transition plan, the IL counselor should consult with the Chief of Community Integration Services regarding the waiting list and availability of funds. If no PAS funds are projected to be available, the transition may be delayed.

MFP Financial Guidelines and Comparable Benefits

- Counselors should staff any IL referral who might meet MFP presumptive eligibility with the Division's Housing and Transition Specialist in order to access all comparable benefits that might be available.

- For clients who are utilizing both MFP and DPP funding, available MFP funding must be committed prior to utilizing DPP funds.
- The Division has waived the financial needs test for services funded by MFP up to the MFP thresholds. Generally, MFP funds cannot exceed $3000 of Transition Year Stability Resource (TYSR) funds and an additional $5000 over and above funds may also be available. The IL Counselor may contact the Housing and Transition Specialist to apply for up to $5000 MFP Over and Above Funds when planning services.
- MFP services are subject to comparable benefits. For example, although not all MFP referrals will require CAP level of care, CAP-DA is considered to be a comparable benefit for MFP Transition Services. When an individual's CAP budget allows for CAP to contribute to transition services, these funds should be applied. The identification of CAP as a comparable benefit, however, should not delay MFP Transition service provision.
- Although the financial needs test is waived to utilize MFP funds, a FNS must be completed in the caseload management system in order to authorize services. In many cases both MFP and IL funds will need to be utilized. The client must meet the IL financial needs test in order to authorize for services utilizing IL funds, but when there is blended funding, the counselor must complete the FNS. The following scenarios apply:
    - If the IL Financial Needs test is met, the Counselor proceeds in authorizing for transition services with MFP reimbursing IL up to the maximum TYSR funds available ($3000 or $3000 plus pre-approved over and above funds). IL may sponsor the excess depending on the availability of IL funds in accordance with all other relevant policy requirements.
    - If only MFP funds are expected to be required or the IL Financial Needs Test is not met, the Division has approved extenuating circumstances allowing the IL Counselor to authorize for the transition services in the amount equivalent to the maximum TYSR funds available ($3000 or $3000 plus pre-approved over and above funds) with the understanding that MFP will reimburse the Division these funds. Essentially, the Division is waiving consideration and application of the client's excess resources towards the costs of transition services that MFP will reimburse to the Division. However, the client is required to contribute their excess resources as recorded on the IL Financial Needs test toward any sum that exceeds the MFP $3000. The Counselor shall document 'MFP Waiver' for these extenuating circumstances under the remarks – Extenuating Circumstances/Justification Section of the Financial Needs Survey (FNS). If there are excess resources that the client will need to contribute in excess of the MFP amount, the Counselor must also document the manner in which the client will contribute the excess on the form. If the excess is to be applied to the transition cost, the client must pay the vendor directly prior to the Transition services being initiated. The vendor should credit the client's contribution on the invoice submitted to the Division.

- Any project requiring the expenditure of IL funds (non-reimbursed expenses) will be contingent on the availability of IL funds regardless of whether MFP funds can be accessed. (Volume VIII, Section 3-7-3) A $12,000 limit of the Division's State appropriated case expenditures per client per lifetime shall be placed on residence modification projects in general, with specific project limits based on the type of residence (currently $12,000 for a site built home and $8,500 for a mobile / manufactured home).
- Regardless of the funding blend of IL and/or MFP monies or other comparable benefits, when an individual project is estimated to cost above the specific type of modification limit, an exception must be approved by the Chief of Policy. The request for an exception applies

to all situations including any potential third party contributions and shall be included in the total cost of the project being submitted for consideration by the Chief of Policy.

- When the Division receives reimbursement by a third party such as MFP, the amount of the third party contribution shall be deducted from the cost of the modification and the lifetime cap of $12,000 of the Division's State appropriated case expenditures per client.

Please note: *When there are unusual or complicated financial situations, consult with the Unit Manager or QDS for guidance.

MFP Procedures

- The Division's Housing and Transition Specialist receives the MFP referral and assigns to the Transition Coordinator.
- Alternately, the IL Counselor should first staff any referral who might meet MFP presumptive eligibility with the Division's Housing and Transition Specialist in order to meet the MFP timelines and access all comparable benefits that might be available.
- The Transition Coordinator gives the MFP referral information to the IL counselor which must include the MFP Application and Pre-Transition Checklist.
- The IL counselor contacts the referral and completes the IL application and presumptive eligibility process within 30 days of receiving the MFP application.
- The IL counselor should review required transition services with the Transition Coordinator to determine whether these services will be required to complete the comprehensive assessment or are identified as a result of the comprehensive assessment.
- The IL counselor determines financial need. If the client does not meet financial need, contact the Housing and Transition Specialist to discuss whether IL can assist with services that are not subject to financial need or if client should be referred to another lead agency for transition assistance. (NOTE: MFP referrals should not be screened out just because the individual will not meet financial need. Services not subject to financial need could be provided.)
- The DVR MFP Transition Coordinator develops the Transition Plan jointly with the IL Counselor, and a copy of the plan is provided to the IL Counselor, family and other transition team members.
- The IL Service Plan is developed to include MFP Transition Services based on the Transition Plan. The Transition Coordinator can assist in confirming comparable benefits and identifying service providers. Authorizations in BEAM must be approved by the Division's Housing and Transition Specialist.
- The authorization for expenditures for TYSR funds must be approved in BEAM by the Division's Housing and Transition Specialist and a copy of the bill must be submitted to the State Office (send to the attention of the Housing and Transition Specialist). The Housing and Transition Specialist will submit a TYSR form with a copy of the bill to MFP for reimbursement.

Post Closure Services

After transition has occurred and the IL case has been closed, any remaining $3000.00 of the MFP Transition Year Stability Resources (TYSR) funds may be available for up to one year from the date of the transition. The counselor must consult with the Division's Housing and transition Specialist to verify the availability of funds. To access these funds, services will be provided in post closure status 32.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF VOCATIONAL REHABILITATION SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

CLAUDIA B. HORN, M.S.
SENIOR DIRECTOR

TARA K. MYERS
DIVISION DIRECTOR

****OBSOLETE - EFFECTIVE 8/15/2019****
Replaced by Interim Policy and Procedure Directive #3-2019

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **February 20, 2017**

Re: **Interim Policy and Procedure Directive #1- 2017: Voter Registration**

Effective: March 1, 2017

Voter Registration Policy

Background:
The National Voter Registration Act (NVRA) of 1993 was enacted to enhance voting opportunities for citizens, including individuals with disabilities who have historically low voter registration rates. NVRA requires that voter registration and the opportunity to update voter registration is made available to applicants and clients receiving services from designated State Agencies.

VR/IL staff are required to provide the same level of assistance in completing the Voter Registration Form as would be offered in the completion of other agency forms. It should be explained to the client that registering or declining to register to vote will not affect services provided by the Division. Agency staff must not seek to influence a client's political preference or party affiliation and must refrain from displaying campaign bumper stickers, wearing campaign or party buttons, pins etc. while conducting voter registration business.

Procedures:
VR/IL staff must make voter registration available to individuals age 18 or older, and preregistration for individuals who are age 16 or 17 when the following occur:

- Application for VR/IL services

- Change of address
- Change of name
- Implementation of Post-Closure services

When assisting a client, the official question to ask discretely is ***"If you are not registered to vote where you live now, would you like to apply to register to vote here today?"***

All individuals applying for VR services must be given the North Carolina Voter Registration Application Form. They may complete the form with VR/IL assistance, or may choose to take the form to complete at a later time. These forms need to be requested through the NC State Board of Elections and an adequate supply is to be on hand at every location clients are served. It is imperative that all forms used by the Division to be coded with the agency code "02" at the top so that it can be tracked appropriately.

The Voter Registration Preference form is launched in BEAM on the demographic form. The appropriate option should be selected on the Voter Registration Preference Form based on the client's decision:

- YES, I would like to apply to register/preregister to vote here today
- YES, I would like to apply to register/preregister to vote, but I will take a voter registration application home to complete at a later time
- NO, I am declining the opportunity to register/preregister to vote today
- I am ALREADY REGISTERED to vote at my current address
- I am ALREADY REGISTERED but I would like to update my voter registration information. I will complete a voter registration Application/Update form for this purpose

The Voter Registration Preference Form must be completed in BEAM in order to track compliance with NVRA and generate internal reports when required. The Spanish version of the Voter Registration Preference form is available on the NC State Board of Election website.

Each unit office shall have a designated NVRA site coordinator who is responsible for sending newly completed, updated Voter Registration forms to the appropriate county Board of Elections within five workdays. In turn, each satellite office will have a designated NVRA coordinator who is responsible for sending newly completed, updated Voter Registration forms to the appropriate county Board of Elections within five workdays.

Retention of records

Copies of all mailed or faxed transmittals submitted to the county Boards of Elections shall be retained in the respective unit/satellite offices for a period of 2 years for auditing purposes. No copies of completed Voter Registration forms shall be retained.

Resources

NC State Board of Elections:
website: http://www.ncsbe.gov/Voter-Registration/NVRA
Phone: 1-866-522-4723

[52 U.S.C. § 20501 - 52 U.S.C. § 20511; NCGS §163-82.20]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF VOCATIONAL REHABILITATION SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

CLAUDIA B. HORN, M.S.
SENIOR DIRECTOR

TARA K. MYERS
DIVISION DIRECTOR

OBSOLETE - EFFECTIVE 3/1/2018
Replaced by Interim Policy and Procedure Directive #1-2018

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **February 22, 2017**

Re: **Interim Policy and Procedure Directive #2-2017: FNS Allowable Net Monthly Income Table**

Effective March 1, 2017

Increase in Allowed Net Monthly Income Amounts on Financial Needs Survey

Due to changes in federal poverty guidelines the following increases to Allowed Net Monthly Income will go into effect on March 1, 2017

Family Size	Poverty Guideline (100% Annual Income)	Poverty Guideline (125% Monthly Income)
1	12060	1256
2	16240	1692
3	20420	2127
4	24600	2563
5	28780	2998
6	32960	3433
7	37140	3869
8	41320	4304
8+	4180	435

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MAILING ADDRESS: 2801 MAIL SERVICE CENTER • RALEIGH, NC 27699-2801
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

The paper-based form, available on the agency Intranet, and the electronic form, in BEAM, have been updated accordingly. Those using the paper-based form in the field should verify that they have the latest version of the form. The following will appear at the top of the current paper-based form:

Financial Needs Survey Worksheet (effective 03/01/2017)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF VOCATIONAL REHABILITATION SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

CLAUDIA B. HORN, M.S.
SENIOR DIRECTOR

TARA K. MYERS
DIVISION DIRECTOR

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **June 16, 2017**

Re: **Interim Policy and Procedure Directive #3-2017: Functional Electrical Stimulation (FES) or Foot Drop Stimulator (FDS) Systems**

Effective July 1, 2017 NCDVRS will not sponsor Functional Electrical Stimulation (FES) or foot drop stimulator (FDS) systems. There is not enough data to support the medical or vocational benefits from the use of these devices. More specifically, clinical evidence does not demonstrate that there might be enough improvement in function, sustainable over a whole workday and work week, that would be great enough to make a substantial meaningful difference in the types of jobs an individual can perform or in increasing an individual's independence.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF VOCATIONAL REHABILITATION SERVICES

ROY COOPER
GOVERNOR

OBSOLETE - EFFECTIVE 3/1/2019
Replaced by Interim Policy and Procedure Directive #1-2019

MANDY COHEN, MD, MPH
SECRETARY

TARA K. MYERS, MS, CRC, CPM
INTERIM SENIOR DIRECTOR/DIVISION DIRECTOR

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **February 15, 2018**

Re: **Interim Policy and Procedure Directive #1-2018: FNS Allowable Net Monthly Income Table**

Effective: March 1, 2018

Increase in Allowed Net Monthly Income Amounts on Financial Needs Survey

Due to changes in federal poverty guidelines the following increases to Allowed Net Monthly Income will go into effect on March 1, 2018

Family Size	Poverty Guideline (100% Annual Income)	Poverty Guideline (125% Monthly Income)
1	$12,140	$1,265.00
2	$16,460	$1,715.00
3	$20,780	$2,165.00
4	$25,100	$2,615.00
5	$29,420	$3,065.00
6	$33,740	$3,515.00
7	$38,060	$3,965.00
8	$42,380	$4,415.00
8+	$4,320	$450.00

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AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

The paper-based form, available on the agency Intranet, and the electronic form, in BEAM, have been updated accordingly. Those using the paper-based form in the field should verify that they have the latest version of the form. The following will appear at the top of the current paper-based form:

Financial Needs Survey Worksheet (effective 03/01/2018)

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
TARA MYERS, MS, CRC, CPM • Senior Director

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **July 13, 2018**

Re: **Interim Policy and Procedure Directive #2-2018:**
Documents to be Signed and Retained in the Case Record

Effective: August 1, 2018

Until we have a completely paperless case management system, it will be necessary to maintain a hard copy case record. This policy directive identifies specific BEAM generated documents that must be printed and maintained in the hard copy case record. All documents that require a client/guardian signature must be printed in their entirety, signed by the client/guardian, and retained in the case record. There are other documents that must be printed and given to the client. For auditing purposes and consistency, these documents should also be copied for the case record.

Specific documents include:

- Agreement of Understanding/Application
- Release of Information Forms
- Eligibility Decision Letter
- Financial Needs Survey - when client signature is required
- BANC Form – if applicable
- IL Service Plan
- Progress reviews
- Annual reviews
- Revisions

- Amendments
- Social Security Administration Information Form when used for income verification
- Documents (email correspondence, memos) verifying approval external to BEAM. Examples include MFP, DPP, policy exceptions
- Documents created by a CIC, AUM that require approval by UM. Examples include status 26 closures, FNS with categories of excess income applied and extenuating circumstances.

It is not required to print and retain the following, but at the discretion of the counselor may be printed and retained in the case record:

- WRAP
- Authorizations
- Joint VR/IL Cases – not required to print concurrent documents
- IL Eligibility

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
CHRIS EGAN, MSW, LCSW • Senior Director

OBSOLETE - EFFECTIVE 3/1/2020
Replaced by Interim Policy and Procedure Directive #01-2020

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **February 22, 2019**

Re: **Interim Policy and Procedure Directive #1-2019: FNS Allowable Net Monthly Income Table**

Effective: March 1, 2019

Increase in Allowed Net Monthly Income Amounts on Financial Needs Survey

Due to changes in federal poverty guidelines the following increases to Allowed Net Monthly Income will go into effect on March 1, 2019

Family Size	Poverty Guideline (100% Annual Income)	Poverty Guideline (125% Monthly Income)
1	$12,490	$1,301
2	$16,910	$1,761
3	$21,330	$2,222
4	$25,750	$2,682
5	$30,170	$3,143
6	$34,590	$3,603
7	$39,010	$4,064
8	$43,430	$4,524
8+	$4,420	$460

The paper-based form, available on the agency Intranet, and the electronic form, in BEAM, have been updated accordingly. Those using the paper-based form in the field should verify that they have the latest version of the form. The following will appear at the top of the current paper-based form:

Financial Needs Survey Worksheet (effective 03/01/2019)

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
CHRIS EGAN, MSW, LCSW • Senior Director
KATHIE B. TROTTER, MS, CRC, LPC, CPM • Director

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **July 1, 2019**

Re: **Interim Policy and Procedure Directive #2-2019: Direct Express**

Effective: July 15, 2019

Cross reference: Section 3-8: Financial Need and Client Resources

Recipients of Social Security benefits have the option of using Direct Express or Netspend for the deposit of funds. Recently both Direct Express and Netspend have changed their processes for providing written balance statements and verification of funds by phone. Recipients may now only request a statement for the current month, rather than three months as required by FNS policy. The following adjustment is being made to the requirement to obtain three months of statements from a client and any applicable family members:

- SSI recipient only (no SSDI/retirement) – no verification from Direct Express or Netspend is required. The recipient should sign the BANC form indicating they have no additional accounts.

- SSDI/Retirement – only one current (within the past 30 days) statement is required to meet the policy requirement noted in the FNS policy. If the recipient is unable to obtain one statement, the Unit Manager can review the specific circumstances and approve waiving this requirement as allowed in Extenuating Circumstances.

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MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **August 1, 2019**

Re: **Interim Policy and Procedure Directive #3-2019: Voter Registration**

Effective: August 15, 2019

Voter Registration Policy

Background:
The National Voter Registration Act (NVRA) of 1993 was enacted to enhance voting opportunities for citizens, including individuals with disabilities who have historically low voter registration rates. NVRA requires that voter registration and the opportunity to update voter registration is made available to applicants and clients receiving services from designated State Agencies.

Vocational Rehabilitation and Independent Living Program (VR/IL) staff are required to provide the same level of assistance in completing the Voter Registration Form as would be offered in the completion of other agency forms. It should be explained to the client that registering or declining to register to vote will not affect services provided by the Division. Agency staff must not seek to influence a client's political preference or party affiliation and must refrain from displaying campaign bumper stickers, wearing campaign or party buttons, pins etc. while conducting voter registration business.

Procedures:

VR/IL staff must make voter registration available to individuals age 18 or older, and preregistration for individuals who are age 16 or 17 when the following occur:

- Application for VR/IL services
- Change of address
- Change of name
- Implementation of Post-Closure services
- When assisting a client, the official question to ask discreetly is **"If you are not registered to vote where you live now, would you like to apply to register to vote here today?"**

All individuals applying for VR services must be given the North Carolina Voter Registration Application Form regardless of their decision to receive assistance with completing and transmitting their application to register to vote. They may complete the form with VR/IL assistance, or may choose to take the form to complete at a later time. These forms need to be

requested through the NC State Board of Elections and an adequate supply is to be on hand at every location clients are served. It is imperative that all forms used by the Division to be coded with the agency code “02” at the top so that it can be tracked appropriately.

The Voter Registration Preference form is now incorporated within the Application /Agreement of Understanding and <u>is no longer launched in BEAM on the demographic form</u>. The appropriate option should be selected on the Voter Registration Preference Form based on the client’s decision:

- YES, I would like to apply to register/preregister to vote here today
- YES, I would like to apply to register/preregister to vote, but I will take a voter registration application home to complete at a later time
- NO, I am declining the opportunity to register/preregister to vote today
- I am ALREADY REGISTERED to vote at my current address
- I am ALREADY REGISTERED but I would like to update my voter registration information. I will complete a voter registration Application/Update form for this purpose

If the Spanish version of the Voter Registration Preference form is required, it is available on the NC State Board of Election website and is to be presented to the applicant and attached to the Application for services / Agreement of Understanding.

Each unit office shall have a designated NVRA site coordinator who is responsible for sending newly completed, updated Voter Registration forms to the appropriate county Board of Elections **<u>within five (5) workdays.</u>** In turn, each satellite office will have a designated NVRA coordinator who is responsible for sending newly completed, updated Voter Registration forms to the appropriate county Board of Elections **<u>within five (5) workdays</u>**. The NC NVRA Agency Transmittal Form is to be used and source type 02 is to be designated.

Remote Transactions:
Whenever a client indicates they have an address or name change and are interested in registering to vote or updating their address/name, they may receive an application to register to vote on site or it is permitted to mail or securely e-mail an application to register to vote to the individual. If the individual indicates interest and has accepted to receive an application to vote remotely, NC NVRA prefers this transaction to be documented using their NVRA REMOTE TRANSACTION SHEET to demonstrate compliance with this requirement.

Retention of records:
Copies of all mailed or faxed transmittals submitted to the county Boards of Elections shall be retained in the respective unit/satellite offices for a period of 4 years for auditing purposes.
Additionally, each office is to maintain a Voter Registration Application Handling Log that records the client ID, dates application to vote are completed and transmitted to the appropriate county Board of Elections office. This document will be subject to audit.

Any completed NVRA Remote Transaction Sheets shall be retained in the case record. No copies of completed Voter Registration Application forms shall be retained.

Training Requirements:
Staff are to review this policy annually and be apprised of any procedural or policy changes as directed by statute or State Board of Elections.

Posters:
Posters as provided by the NC Board of Elections indicating that applicants may apply to register to vote at the office are to be displayed in the office lobby of all offices where individuals apply for services.

Resources:
NC State Board of Elections:
Website: http://www.ncsbe.gov/Voter-Registration/NVRA

Phone: 1-866-522-4723

[52 U.S.C. § 20501 - 52 U.S.C. § 20511; NCGS §163-82.20]

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MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **August 1, 2019**

Re: **Interim Policy and Procedure Directive #4-2019: Revised Paper Application**

Effective: August 15, 2019

Interim Use of Revised Paper Application For IL Services/Agreement of Understanding

Background:

The Application /Agreement of Understanding has been updated as follows:

- Incorporating the NVRA Voter Registration Preference Form as a medium to document in writing that every applicant was extended the opportunity to register to vote;
- Additional language informing applicants of our need to access databases with information relevant to service provision needs and reporting requirements;
- Informing applicants of the risks associated with digital communications and social networking.

Until further notice, the paper application will need to be used with every new applicant and will need to be thoroughly completed with all signatures and appropriate boxes checked within the Voter Registration Preference section of the application. There is no need to re-do any application that was taken prior to the effective date of this directive.

Once the paper copy has been signed by all required individuals, the electronic BEAM case management version will need to be electronically dated and signed (via electronically dating).

The hard copy is to be retained in the official case record and it is preferred to have the completed document scanned and uploaded within the electronic case management system as a case note attachment to facilitate case reviews and audits.

The objective is to have the application incorporated within BEAM case management system, which will require development. Templates of the interim applications will be made available via the SharePoint site under Forms>BEAM Forms> beam_IL_application_agreement_revised.

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MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **February 21, 2020**

Re: **Interim Policy and Procedure Directive #01-2020: FNS Allowable Net Monthly Income Table**

Effective: March 1, 2020

Increase in Allowed Net Monthly Income Amounts on Financial Needs Survey

Due to changes in federal poverty guidelines the following increases to Allowed Net Monthly Income will go into effect on March 1, 2020

Family Size	Poverty Guideline (100% Annual Income)	Poverty Guideline (125% Monthly Income)
1	$12,760	$1,330
2	$17,240	$1,796
3	$21,720	$2,263
4	$26,200	$2,729
5	$30,680	$3,196
6	$35,160	$3,663
7	$39,640	$4,129
8	$44,120	$4,596
8+	$4,480	$467

The paper-based form, available on the agency Intranet, and the electronic form, in BEAM, have been updated accordingly. Those using the paper-based form in the field should verify that they have the latest version of the form. The following will appear at the top of the current paper-based form:

Financial Needs Survey Worksheet (effective 03/01/2020)

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MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **April 1, 2020**

Re: **Interim Policy and Procedure Directive #02-2020: Verbal/Email Agreement for Client Signatures**

Effective: Immediately

Verbal/Email Agreement for Client Signatures

Due to Executive Order 121 and the need for teleworking and limiting in-person meetings in response to COVID-19, obtaining client signatures on VR and IL casework forms has become challenging. In order to continue service delivery during this time the ability to obtain verbal or email agreement in lieu of a client's physical signature is effective immediately and will remain in effect until staff are able to return to work in their respective offices. The agreement should be specific to a completed casework document, and not a general agreement from a client for all VR or IL documents.

Verbal or email agreements cannot be obtained on Consent for Release of Medical Information forms. These forms still require the client's actual signature in order to obtain medical or disability specific information from a Medical Provider.

Documentation Requirements
Staff must document on the contact note footer associated with the specific form when verbal or email agreement for a signature has been received by a client. If verbal (i.e. by phone) the contact note footer must document the conversation. If the agreement was obtained via email a copy of the email exchange should be uploaded to the case note. Upon completion of the documentation on the contact note footer the client's signature on the casework document may be electronically signed and dated for the client in the case management system.

Note: An actual signature is preferable whenever possible. Please make every effort to secure a signature via mail, fax or DocuSign before utilizing a verbal or email signature agreement. Should you have any questions regarding specific circumstances with obtaining client signatures that affect service delivery contact your QDS or the Policy Office for guidance.

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****OBSOLETE - EFFECTIVE 7/15/2020****
Replaced by Interim Policy and Procedure Directive #06-2020

MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **April 13, 2020**

Re: **Interim Policy and Procedure Directive #03-2020: Revised Residence Modification Process in Response to COVID-19**

Effective: Immediately

Process for Residence Modifications during COVID-19 Restrictions

New Projects – New Referrals

- Exterior ONLY projects may continue.
- Interior ONLY projects are on HOLD.
- WHEN BOTH interior & exterior are in the referral - Engineer completes report for exterior modifications ONLY and proceeds in accordance with policy guidelines.
- When social distancing restrictions are lifted, and interior modifications can be considered, the engineer will complete a separate report for interior modifications. These will be considered two separate projects. Lifetime limits apply.

Existing projects – Referral has been taken and the site visit was completed.

- Exterior ONLY projects may continue.
- Interior ONLY projects are on HOLD.
- WHEN BOTH interior & exterior are in the referral –
    - If the project has already been awarded the contractor can complete the exterior project and bill VR/IL for that portion. Labor charges should be specific to that portion of the work and must be considered usual and customary to be approved by the engineer. When social distancing restrictions are lifted the same contractor should complete the interior project. The total project cost should not exceed the awarded amount without prior approval.
    - If the project has not been bid or awarded the engineer will complete two reports separating the interior and exterior projects. Proceed with providing exterior modifications. When social distancing restrictions are lifted the interior modification portion can be bid and awarded in accordance with policy guidelines.

- If the project has been bid but not awarded **the bid process will be cancelled**. The engineer will need to separate into two projects and rebid the exterior portion only. When social distancing restrictions are lifted, and interior modification can be considered the interior modification will be done as a separate project.

Additional information:

- Lifetime limits apply to projects that are being completed in two separate phases.
- DPP – All applications to reserve DPP funds must be for the full residence modification project (interior only; exterior only; or both interior and exterior). Submit all invoices with the request for reimbursement when the full project is complete.
- DPP - For New Referrals ONLY:
  - For exterior projects, DPP applications may proceed as usual.
  - For interior projects, DPP applications should be on HOLD.
  - For BOTH interior & exterior projects it is assumed the total estimate would exceed $10,000, so the DPP application should be for the full amount of whatever funds are available up to that $10,000 maximum.
- If there are questions about how to handle specific cases, please consult with Steve Brink or the Policy Office for guidance.

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MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **June 1, 2020**

Re: **Interim Policy and Procedure Directive #04-2020: Background Checks**

Effective: Immediately

Background Checks

As part of the rehabilitation process it is sometimes useful to have detailed information about a client's criminal history. On occasion clients are not fully aware of all convictions and thus accurate information can be a helpful tool for vocational counseling, determination of appropriate services and/or employment goals. Background checks may be purchased from approved vendors to aid in the rehabilitation process.

- Under no circumstances will these background checks be given to employers or used in lieu of the employer's required screening process.
- VR sponsored background checks may not be conducted for participation in any CRP service.

Clients must provide written consent to obtaining a background check. Some DVRS approved vendors may supply their own consent forms for clients to sign as part of the referral process. If a vendor does not provide consent forms prior to requesting a background check, written consent using the DHHS-1000 Consent Form must be obtained. In addition, the client must sign the Authorization Disclosure Form DVR-1030 which provides specific information regarding his/her rights under the Fair Credit Reporting Act. A copy of the forms must be attached to the Consent form and copies given to the client.

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MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **June 3, 2020**

Re: **Interim Policy and Procedure Directive #05-2020: Using Approved Videoconferencing Technologies to Provide Services Remotely**

Effective: June 15, 2020

Background

The objective of this policy directive is to provide guidance for the provision of services using NC DVRS-approved secure remote technologies (videoconferencing) in response to the COVID-19 Nationwide Public Health Emergency that will allow the Division to continue to serve and minimize risks to the population served.

Using videoconferencing technologies to provide services remotely is not appropriate for every consumer and every situation; therefore, it is imperative for staff to exercise their professional judgement along with the policy guidance provided in this directive to decide on the appropriateness of a remote service intervention for their consumer.

Further, guidelines and procedures within this directive are to assure service providers are utilizing secure technologies and required procedures to be compliant with current regulations for consumer protection.

Part I: General Provisions:

1) **Approved Videoconferencing Technologies for Division Staff Use for Serving Consumers Remotely** : Microsoft Teams; Google G Suite Meet; *Zoom.gov* is **NOT** approved for discussion of healthcare-related information at this time.*

   NOTE: Only agency-licensed subscription-level versions of the software as supplied by the Division will be permitted for this activity.

   Approved Videoconferencing Technologies for Service Provider Use with HIPAA Business Associate Agreement (BAA) in Place with Videoconferencing Service Provider and DHHS BAA: Licensed subscription applications of the following: Cisco

Webex Meetings/Webex Teams; GoToMeeting; Zoom for Healthcare; Google G Suite Hangouts Meet; Microsoft Teams.

Unapproved Technologies for Remote Services Delivery: No public-facing, unlicensed or freeware remote communication products (audio and video) will be approved for use in serving consumers, including: Facebook Live; Twitch, TikTok, Slack, Skype (freeware).

2) **Use Restrictions:** NC DVRS-approved videoconferencing technologies can be used for confidential videoconference discussions and live review (display) of documents.
   - It is NOT permissible to:
     - record sessions with consumers;
     - upload, insert within chat, or store consumer-related documents within the application.

3) **Accessibility Requirements:** Staff and service providers shall reasonably accommodate the disability-specific needs of consumers to the greatest extent feasible when employing remote technologies to deliver services.

4) **Breaches:** Service Providers shall report security breaches or incidents while delivering services using remote technologies to the DHHS Privacy and Security Office https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security within 24 hours of the incident. Staff shall report such an incident to the policy office dvr.m.policyoffice@dhhs.nc.gov within 24 hours. An example of a breach incident would be if an unauthorized individual accessed protected data during a closed videoconference session or through a practice commonly referred to "hijacking" where an uninvited unauthorized guest disrupts a videoconference session.

5) **Services outside the scope of this Directive:**
   a. Medical telehealth or telepsychiatry appointments under the umbrella of a hospital, or healthcare provider network system, or service provider approved by NC Medicaid to provide such services.
   b. CRP-related services under contract, including CRP-provided Pre-Employment Transition Services)

6) **Service Rates:** Service rates for purchased services using remote technologies will be based on the same payment methodologies used for comparable services provided in-person.

7) **Approved Services:** The following list of services can be provided using remote video conferencing methods by staff or by service providers approved by the policy office to provide services remotely. Only approved services can be provided remotely using videoconferencing technologies.

   Exceptions or possible additions to this list must receive prior approval by the Chief of Policy.
   - Assistive Technology/Consultation Services from NCATP—family of services
   - Assistive Technology/Consultation Services -- (consultation, training)—family of services from other providers

- Benefits Counseling -- agency provided
- Benefits Counseling – purchased
- Community Inclusion Services
- Guidance and Counseling -- agency provided
- Employment Marketing Skills -- agency provided
- Job Club- agency provided
- Job Supports
- Pre-Employment Transition Services -- agency provided or purchased outside of contract
- Psychological Consultation
- Psychological Evaluation
- Tutoring, academic support services
- Vocational Evaluation—agency provided or purchased

8) **How to authorize services approved to be provided using remote technologies:**
   - When authorizing, specify that the service is to be provided remotely using approved remote technologies, including videoconferencing.
   - Only authorize to service providers approved by the Division to provide services remotely as covered within the scope of this directive.
9) **Serving minors and consumers with legal guardianship:** Ensure permission is obtained by guardians prior to engaging minors or consumers with legal guardians using remote videoconferencing technologies and documented within the case.

Part II: Services Provided Directly by Agency Staff Using Approved Remote Technologies [Including NCATP]:

If staff need to engage consumers beyond traditional methods of phone, secure e-mail, and mail, through the use of videoconferencing, the consumer must be supported to understand this method and approach to service delivery and agree (consent) to receive services remotely. Remote service delivery is permissible only when using the approved technologies as specified within this directive. Staff are to follow the procedures for engagement and documentation as indicated.

Staff engaging consumers through Division-approved remote technologies must use a secure state network connection whenever possible or VPN (Virtual Personal Network) when working remotely. This ensures a secure network environment.

Consumer-related video conferencing sessions are not to be recorded, nor consumer-related documents stored within the application, as the privacy or protection of the stored information cannot be guaranteed. For example, it is okay to open and share (display) a consumer document (e.g., a resume or an IPE) while using the videoconferencing application; however, it is NOT okay to post a file to the chat feature of the application where it might be stored.

Approved Videoconferencing Technologies for Division Staff Use for Serving Consumers Remotely: Microsoft Teams; Google G Suite Meet; *Zoom.gov* is **NOT** approved for discussion of healthcare-related information at this time*.

NOTE: Only agency-licensed subscription-level versions of the software as supplied by the Division will be permitted for this activity.

Procedures for Remote Service Delivery by Division Staff:

- **Consumer Notification:** Notify the consumer within an adequate timeframe to confirm an appointment where remote videoconferencing technology will be used. Include appropriate instructions on how to engage in videoconferencing, encouraging them to participate the best they can to enable their case to progress. Staff are to clearly identify themselves and their affiliation with the NC Division of Vocational Rehabilitation Services, commonly referred to as "VR."
- When scheduling a videoconferencing appointment, staff are expected to notify consumers about the potential for privacy risks when using videoconferencing products. The following script shall be used and modified for comprehension as appropriate:

  "Dear (consumer name),

  NC Division of Vocational Rehabilitation (VR) has an alternative for providing services to you in light of the COVID-19 pandemic. In order to reach you and provide services, a videoconferencing solution can be used. Please be informed that there is a potential risk to your personal and protected health information when using remote technologies. However, the Division has taken measures to reduce these risks to the maximum extent possible. Would you like to proceed with a meeting with VR staff using videoconferencing? Yes or No"

- **Documentation:** The presentation of this statement, method of delivery, and response is to be documented in a case note.

Part III. Services Provided Remotely by Service Providers within the Scope of this Directive:

This section, along with applicable general provisions in Part I above apply to service providers:

Approved Videoconferencing Technologies for Service Provider Use with HIPAA Business Associate Agreement (BAA) in Place with Videoconferencing Service Provider and DHHS BAA: Licensed subscription applications of the following: Cisco Webex Meetings/Webex Teams; GoToMeeting; Zoom for Healthcare; Google G Suite Hangouts Meet; Microsoft Teams.

Accessibility Requirements: Service providers shall reasonably accommodate the disability-specific needs of consumers to the greatest extent feasible when employing technologies to provide services remotely.

Process for Approving Service Providers for Remote Service Delivery:

Existing approved NCDVRS service providers who currently provide in-person services above and are seeking approval to provide a remote version of the service must be approved to do so prior to providing such services to ensure that all protections are in place and the service provider has been advised of the required procedures:

1) Complete the "NCDVRS Application to Provide Remote Services" along with required attachments (NC DHHS Business Associate Addendum, etc.) and have the sponsoring VR office designee submit using Zixmail or other secure methods to the Assistant Regional Director for their initial review/endorsement and then to the policy office dvr.m.policyoffice@dhhs.nc.gov for review/approval.

2) Request will be reviewed and, if approved for the provision of specific service(s) using remote technologies/videoconferencing, a notification will go to the applicant service provider, Assistant Regional Director, and office designee who submitted the request.

   The notification will include the expectations for engaging consumers via remote access and will specify the additional required documentation to be included along with provider invoices and reports.

3) Approval to provide remote services can be revoked by the Division at any time should there be concerns about service quality, effectiveness of the approach, security, or non-compliance with agency requirements.

4) Service providers who have not yet been approved as Division vendor will first need to be approved in BEAM for the specific VR service according to the Division's vendor approval process currently in place. Once approved as a Division vendor with an activated vendor record in BEAM, this directive should be followed for the provider to be considered for remote service delivery. These processes can be initiated concurrently as appropriate.

Procedures for Remote Service Delivery by Service Providers

Once approved by the Division for delivery of one or more services using remote means, service providers shall use the following procedures:

- Notify the consumer within an adequate timeframe to confirm an appointment with appropriate instructions on how to receive services remotely, encouraging them to participate the best they can to enable their case to progress. Service providers and staff are to clearly identify themselves and their affiliation with the NC Division of Vocational Rehabilitation Services, commonly referred to as "VR."
- Service providers are expected to notify consumers about the privacy risks to their information while using approved videoconferencing technologies. The following script shall be considered/modified for comprehension as appropriate:

"Dear (consumer name),

Our service provider group has the ability to provide an alternative way to provide services to you on behalf of the Division of Vocational Rehabilitation Service (VR) in light of the COVID-19 pandemic. In order to reach you and provide services, a videoconferencing solution can be used. Please be informed that there is a potential risk to your personal and protected health information when using remote technologies. However, the Division has taken measures to reduce these risks to the maximum extent possible. Would you like me to proceed with providing you the services recommended by NC Division of Vocational Rehabilitation (VR)? Yes or No"

- The presentation of this statement, method of delivery, and response is to be documented in the resulting service provider's report.

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MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **July 6, 2020**

Re: **Interim Policy and Procedure Directive #06-2020: In-Home and In-Person Services Provision During COVID-19 Pandemic**

Effective: July 15, 2020 *(Remains effective until superseded by an updated Directive reflecting new guidance)*

Background:
The objective of this policy directive is to provide guidance for the provision of in-person or in-home services when their provision during the COVID-19 pandemic is determined **critical**. Such services are not able to be provided remotely using videoconferencing technologies as permitted by Directives #08-2020 (Vol I) and #05-2020 (Vol 8). Further, guidelines and procedures within this directive are to assure staff and service providers are minimizing health and safety risks to consumers through the consistent use of guidelines and procedures from NC DHHS Division of Public Health and US Center for Disease Control (CDC) to the maximum extent possible.

SCOPE:
This Directive applies primarily to in-consumer home and in-agency office services. The expectation of all other service providers providing community-based in-person services at the direction of the Division are expected to follow all current US Center for Disease Control (CDC), NC DHHS guidelines, and NC Governor's Executive Orders in the provision of services as it applies to the nature and setting of their services.

Part I: General Provisions: These provisions apply to all situations:

1) **Minimize In-Person Contact:** In general, staff and service providers are to use remote options to coordinate, provide services, conduct business and communicate to the maximum extent possible, even if in-person or in-home services are permitted. The objective is to minimize direct exposure to others.

2) **Consent:** Prior to the provision of any in-person or in-home services, the consumer's documented consent to proceed under COVID-19 pandemic conditions must be obtained by NC DVRS counselor or casework staff using form DVR-0189 Consent to Receive In-Person or In-Home Services During Health Emergency. Electronic or

documented verbal signature compliant with Interim Directive #02-2020: Verbal/Email Agreement for Client Signatures is acceptable. Upon request, consumers shall be provided a copy for reference (electronic or paper).

3) **3-W's (Wear, Wait, Wash) During Service Provision:** While in-person or in-home services are being provided by staff or service providers, the following practices shall be consistently applied:

   - Face coverings covering mouth and nose are to be worn at all times by staff and service providers, consumers and family members over the age of 11 present and in proximity of the work activity when in-person or in-home services are being provided. If a consumer or family member within proximity of the work activity is unable to wear a mask as outlined in Governor Cooper's Executive Order 147, the staff/service provider will make a determination of whether they can deliver the service remotely or provide another reasonable measure to provide the service safely. Service providers are responsible for providing PPE (Personal Protective Equipment) for their own use. Should consumers be unable to provide their own face coverings, please refer to separate policy guidance (Volume I Directive #10-2020 and Volume 8 Directive #07-2020).
   - Maintain 6 feet of distance between individuals in-person or on-site to the greatest extent possible at all times. Appointments are to be set when social distancing can be achieved to the maximum extent possible.
   - Staff and service providers/contractors are to clean and sanitize hands by either washing with soap for 20 seconds or use hand sanitizer with minimum 60% alcohol content, whichever is suitable for the situation and minimizes cross-contamination. Service providers/contractors are responsible for providing hand sanitizer for their own use.

4) All service providers providing services to consumers at the direction of the Division are expected to follow all current US Center for Disease Control (CDC), NC DHHS guidelines, and NC Governor's Executive Orders in the provision of services as it applies to the nature and setting of their services.

<u>Part II: Situation-Specific Guidance:</u>

A) **Staff or Service Providers Providing Services in a Consumer's Home:**

   - Only critical projects/work/assessments are to be done inside the home or workplace of a consumer and must be approved by the designated supervisor(s) as instructed within each region.

     Included within this category are items that would significantly improve or protect the health and safety of the consumer while minimizing risk to them, staff, or service providers. These may include work to allow access:
     - into or out of the residence
     - to bathroom facilities where access is not currently possible
     - to food and water when not currently possible
     - to durable medical equipment that is determined essential to maintaining the consumer's health
     - to Personal Assistance Services
     - to technology critical to job retention or health or safety

- Consent**--** It is necessary to obtain the consumer's documented consent to proceed under COVID-19 pandemic conditions. The counselor/case workers assigned to the case will obtain then confirm that the consent is in place **before** services can proceed.

- Gloves – staff and service providers are to wear gloves at all times that they are in the home. Service providers will be responsible for providing gloves for their own use.

- Health Self-Assessment – In addition to staff and service providers conducting the below Health Self-Assessment daily for themselves prior to having contact with others, they are also to ask all people within the home the questions below and respond appropriately according to the responses.

Health Self-Assessment:

1. **Do you or members within your home have any of these symptoms?**
    - **Fever where your temperature exceeded 100.4 °F?**
    - **Chills**
    - **Shortness of breath or difficulty breathing**
    - **New cough**
    - **New loss of taste or smell**

    If yes response to any of the above, all activity shall be suspended until cleared and the affected individual should contact their health care provider.

2. **Are you living with anyone who is sick or quarantined or have been around anyone exhibiting symptoms in question 1 above?**

    If yes response to question 2, all activity shall be suspended until cleared and the individual is strongly encouraged to be tested for COVID-19 virus infection.

In no way should services be provided when any party involved (e.g., consumer, family member, staff, service provider) exhibits symptoms or may be an active carrier of the COVID-19 virus. Service providers are to notify their agency contact (typically staff authorizing service) and agency staff are to notify their supervisors promptly.

Per CDC guidelines, if a staff or service provider/contractor has been diagnosed with COVID-19 or is presumed positive by a medical professional due to symptoms, the person shall be excluded from providing in-person or on-site services until:

- No fever for at least 72 hours/3 days since recovery (no fever persists without use of fever-reducing medicine);

  AND
- It has been at least 72 hours/3 days since symptoms have improved, including cough and shortness of breath;

  AND
- At least 10 days have passed since first symptoms were experienced.

If staff or service providers develop symptoms (consistent with the Health Self-Assessment) after providing in-home or in-person services:

- **staff must notify their supervisor for further instructions.**
- **service providers must notify their Agency point of contact immediately for consultation with Agency supervisors for further instructions**.

If testing is appropriate, www.ncdhhs.gov/TestingPlace is a public website that allows people to enter their county or ZIP code and access a list of nearby testing site locations online.

B) Expectations of Service Providers Providing Services within Designated Agency Office Locations:

In addition to the General Provisions 1-4 above, the following also apply:

- In-person and on-site services are to be provided only when:
  - it is not possible to provide remote services and the provision of in-person and on-site services are determined critical as per regional instruction;
  - a designated area to accommodate the provision of in-office services has been made available for the provision of the specified service.
- Appointments are to be set when social distancing can be achieved to the maximum extent possible
  - The designated space where services are provided is to be cleaned and sanitized prior and after each work session/between consumers. This environmental cleaning and disinfection of high-touch areas will be done with an EPA approved disinfectant for SARS-Cov-2 and in compliance with all other CDC-guidelines pertaining to this service delivery venue.
  - All other DHHS- DVRS office-specific procedures or current CDC guidelines (whichever is more stringent) are to be followed in the provision of services.
- Service providers are expected to provide their own PPE (Personal Protective Equipment).
- The agency will make every effort to provide face masks for consumers who cannot provide their own.

For additional guidance: nc.gov/covid19

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
CHRIS EGAN, MSW, LCSW • Senior Director
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MEMORANDUM

To: All Staff Assigned Volume VIII

From: Vicky Miller – Chief of Policy

Date: **July 6, 2020**

Re: **Interim Policy and Procedure Directive #07-2020: Purchasing Face Coverings for Clients**

Effective: July 15, 2020 (*Remains effective until superseded by an updated Directive reflecting new guidance)*

General Information

NCDHHS recommends that all North Carolinians practice the 3W's when leaving home which include wearing a cloth face covering, waiting 6 feet apart, and washing hands often with soap and water for at least 20 seconds or using hand sanitizer.

Since the wearing of face coverings is required per Executive Order 147 secondary to the highly contagious nature of COVID-19, clients receiving services from IL should adhere to this Executive Order and wear a face covering when participating in IL services to help prevent the spread of COVID-19. If a client is unable to wear a mask as outlined in Executive Order 147 the service provider will make a determination of whether they can deliver the service remotely or provide another reasonable measure to provide the service.

Effective immediately when services require in person contact face coverings can be purchased ***for IL clients who do not have the ability to purchase or obtain them without IL sponsorship***. The provision of face coverings is not subject to financial need. Comparable benefits should be utilized when available.

Counselors should provide resources and information to clients about the NCDHHS guidelines regarding preventing the spread of COVID-19 [NC DHHS website link]. When planning, implementing and providing services that require face to face contact counselors should discuss the requirement to wear face coverings and ensure that the client has appropriate face coverings for the rehabilitation program. When a counselor determines that a client does not have the ability to purchase or obtain face coverings from another source, the following procedures and distribution apply.

Procedures for Purchase and Distribution

Unit Offices may utilize their Client P-card to purchase face coverings for clients. It is not necessary to add the service to the ILSP or generate an authorization. Cardholders should use the same process for reconciling receipts using the Administrative P-Card. On the P-card Reconciliation Form use 1452-23C2-99 for the Center Code and 536102003 for the account number.

Industrial Opportunities is the current approved vendor for this service. Disposable face coverings are available from this vendor in packages of 50.
Contact jessie@elasticproducts.com to place an order.

Any questions regarding procedures for purchasing and invoicing face masks for clients should be directed to the ARD.

Procedures for Tracking

Distribution of face coverings from the bulk supply must be documented on ***DVR Form 7015 - COVID-19 Face Covering Tracking Report***. Record the client name and ID, # of masks given, date provided, Program (VR, IL or AT) and the rationale for providing face coverings. This tracking report will be audited by Fiscal Services on a monthly basis.